

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
STATE LICENSE NUMBER: <b>09750201</b>				
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F 0000	INITIAL COMMENT	F 0000		
F 0580	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey, and Complaint survey completed on July 2, 2025, it was determined that Maple Winds Healthcare and Rehabilitation was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0580		
SS=D				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0580  SS=D	Continued from page 1  483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	Resident 2's physician was notified of her change in condition on November 13, 2024. Resident 2's responsible party was not notified of the change in condition on November 13, 2024 as per her wishes.  Immediate re-education was provided to Registered Nurse by the Director of Nursing regarding the importance of ensuring a resident's physician and responsible family member or legal representative are notified as soon as possible of any changes in the resident's condition.  Any resident who has a change in condition has the ability to be affected by this alleged deficient practice.  A whole house audit of residents who recently had a change in condition was completed to ensure his/her physician and his/her responsible family member or legal representative were notified as soon as possible of the change in the	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0580  SS=D	Continued from page 2  section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).  §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).  This REQUIREMENT is not met as evidenced by:	F 0580	resident's condition.  Licensed nursing staff, including agency licensed nursing staff, re-educated on the facility Notification of Changes Policy, including the importance of ensuring a resident's physician, responsible family member or legal representative are notified as soon as possible of any changes in the resident's condition.  The Director of Nursing/designee will randomly audit notifications of physicians, and responsible family members/legal representatives of residents with changes in condition weekly times eight weeks and then monthly times four months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.  Results of these audits will be reviewed in Quality Assurance and Performance Improvement times six	

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F 0580  SS=D	Continued from page 4  Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the physician and the resident's responsible party regarding a change in condition for one of 35 residents reviewed (Resident 2).  Findings include:  The facility's policy regarding changes in a resident's condition or status, dated March 12, 2025, revealed that physicians, responsible family members or legal representatives would be notified as soon as possible of any changes in the resident's condition.  A quarterly admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated May 31, 2024, revealed that the resident was cognitively intact and had diagnoses that included diabetes, congestive heart failure, and chronic obstructive pulmonary disease. A review of Resident 2's care	F 0580		

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F 0580  SS=D	Continued from page 5  plan, dated November 1, 2023, indicated that the resident had a history of acute (sudden onset) respiratory failure.  A nursing note for Resident 2, dated November 13, 2025, at 6:17 p.m. revealed that when staff entered the resident's room to administer medications, the resident was found to be difficult to wake up and hard to arouse. Vital signs were as follows: blood pressure was 180/100, pulse 107, respirations 19, and oxygen saturation was 97 percent while on 4 liters per minute of oxygen, temperature was 96.3 degrees F. Resident 2 was pale and cold to touch with no sweating. The resident had no urine output, and the bladder was distended. The air conditioner was turned off and a blanket was placed on the resident to keep her warm. The registered nurse supervisor was informed. Resident 2 was placed on her BiPAP (Bilevel Positive Airway Pressure machine, a device that assists breathing by delivering pressurized air through a mask). Straight catheter was performed and drained around 650 milliliters of clear yellowish urine. Staff to continue to observe	F 0580		

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F 0580  SS=D	Continued from page 6  resident for any untoward events. There was no documented evidence in Resident 2's clinical record that the physician or her son was notified about her change in condition.  A nursing note for Resident 2, dated November 18, 2025, at 12:55 p.m. revealed that Resident 2 became pale, unresponsive, and had profuse sweating. The resident had an oxygen saturation of 74 percent and was placed on the BiPAP machine. Resident 2's blood pressure was 110/60 with a temperature of 94.3 degrees. The physician was notified with an order to send to the hospital, and a voicemail was left for the resident's son.  Interview with the Director of Nursing on July 1, 2025, at 1:14 p.m. confirmed that on November 18, 2025, Resident 2 had a change in condition similar to the event on November 13, 2025. However, on November 18, 2025, the physician and son were notified of her declining health status, but on November 13, 2025, per facility policy, the physician and son should have been notified	F 0580		

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F 0580  SS=D	Continued from page 7  regarding the resident's change in condition, and they were not.  28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0580		
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F 0585  SS=D	Continued from page 8  483.10(j)(1)-(4) Grievances  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	Facility's new Social Services Director immediately completed facility grievance/complaint concern forms for the June 14th and June 15th grievances regarding Resident 13 and placed both concerns onto the June 2025 Grievance/Concern and Complaint Log.  Any resident admitted to the facility has the ability to be affected by this alleged deficient practice.  A whole house audit was completed to ensure recent grievances/complaints and/or concerns were placed onto the monthly Grievance/Concern and Complaint Log and a grievance/complaint concern form was completed for the grievance.  Nursing Home Administrator educated the new Social Services Director on the facility Concern/Grievance Policy and the facility grievance/complaint concern form.	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0585  SS=D	Continued from page 9  can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	Nursing Home Administrator/designee will randomly audit the monthly Grievance/Concern and Complaint Log weekly times four weeks and then monthly times three months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.  Results of these audits will be reviewed in Quality Assurance and Performance Improvement times four months or until substantial compliance is noted.	

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F 0585  SS=D	Continued from page 10  date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.  This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585  SS=D	Continued from page 11  Based on review of policies and facility grievance/complaint logs, as well as staff interviews, it was determined that the facility failed to follow its grievance policies regarding maintaining a log of all grievances received for one of 35 residents reviewed (Resident 13).  Findings include:  The facility's policy regarding grievances/complaints, dated March 12, 2025, indicated that a concern form is initiated when a concern/grievance is brought forward by a staff, family, responsible party and/or resident. After obtaining necessary information from the resident, family, responsible party and/or staff the concern form is completed and submitted to the Social Services Director or the Administrator who then distributes it to the appropriate depart head(s). The Social Service Director will log the form into a concern and grievance log. The Social Services Director will maintain a concern and grievance log as well as ensure concerns/grievances are	F 0585		

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F 0585  SS=D	Continued from page 12  completed and followed up with in a timely manner including effectiveness. Results of concerns/grievances will be maintained for a minimum of three years.  A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 13, dated April 9, 2025, revealed that the resident was understood and could understand others.  A Grievance Form for Resident 13, dated June 14, 2025, revealed that the resident's daughter came to visit her mom and went into her room to find a dirty brief lying on the bottom of the bed. When she pulled back the covers, she found that her mom had no brief on, and that she was covered with a bowel movement, as well as her bed linens. Staff immediately went in and cleaned her up as well as her bedding. Staff was notified of the incident as well as the Director of Nursing.  A Grievance Form for Resident 13, dated June 15,	F 0585		

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F 0585  SS=D	Continued from page 13  2025, revealed that the resident's daughter reported that when she came in to visit the resident the other day (unsure of date) that there were some pills in a med cup on the resident's bedside table and that there were pills in her mom's bed, as well as on the floor. She stated that she did report this to the Director of Nursing. The registered nurses and licensed practical nurses were re-educated about not leaving medications or treatment supplies in residents' rooms.  As of July 2, 2025, a review of the facility's complaint/grievance logs for June 2025 revealed no documented evidence that the concerns from Resident 13's daughter about finding the resident covered in a bowel movement and finding medications at the resident's bedside were listed on the facility's grievance/complaint log.  Interview with the Director of Nursing on July 2, 2025, at 9:10 a.m. confirmed that there was no documented evidence as of July 2, 2025, that Resident 13's daughter's concerns about finding the	F 0585		

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STATE LICENSE NUMBER: <b>09750201</b>				
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F 0585  SS=D	Continued from page 14  resident covered in a bowel movement and finding medications at the resident's bedside was listed on the facility's grievance/complaint log.  28 Pa. Code 201.29(c.3)(4) Resident Rights.	F 0585		
F 0628  SS=D		F 0628		

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F 0628  SS=D	Continued from page 15  483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) Discharge Process  §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	Written notification of Resident 2's transfer to the hospital on November 18, 2024 was immediately provided by the new Social Services Director to Resident 2 and the resident's representative.  Facility's new Social Service Director immediately provided Bed-hold notice to Resident 2's responsible party for her transfer to the hospital on November 18, 2024.  Ombudsman was immediately notified by the facility's new Social Services Director, as required, of Resident 2's transfer to the hospital on November 18, 2024.  Written notification of Resident 19's transfer to the hospital on November 5, 2024 was immediately provided by the new Social Services Director to Resident 19's representative.  Facility's new Social Service Director immediately provided Bed-hold notice to Resident 19's responsible party for her transfer to the hospital	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0628  SS=D	Continued from page 16  (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c) (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628	on November 5, 2024.  Ombudsman was immediately notified by the facility's new Social Services Director, as required, of Resident 19's transfer to the hospital on November 5, 2024.  Resident 38 no longer resides in the facility.  Physician Discharge Summary Form completed for Resident 37.  Any resident transferred from the facility to the hospital has the ability to be affected by this alleged deficient practice.  A whole house audit was completed on recent resident transfers to the hospital to ensure written notification was provided to resident and resident's responsible party regarding the reason for transfer to the hospital.  A whole house audit was completed on recent resident transfers to the	

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F 0628  SS=D	Continued from page 17  §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:  (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 0628	hospital to ensure a bed-hold notice was provided to resident's responsible party.  A whole house audit was completed on recent resident transfers to the hospital to ensure the Ombudsman was notified of the transfer to the hospital.  Any resident discharged from the facility has the ability to be affected by this alleged deficient practice.  A whole house audit was completed on recent resident discharges to ensure the Physician Discharge Summary Form has been completed.  Facility's new Social Services Director and Marketing Liaison/Admissions Director educated by Nursing Home Administrator on contacting the resident/resident's representative following a facility-initiated transfer to an acute care facility or hospital, including the need to provide written notification of hospital transfer to	

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F 0628  SS=D	Continued from page 18  for Mentally Ill Individuals Act.  §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.  §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628	resident/resident's representative, the need to provide bed-hold notice to responsible party and the need to notify the Ombudsman as required.  Registered Nurses, including agency Registered Nurses, re-educated on the facility Physician Discharge Summary Policy.  Resident transfers to the hospital will be audited by the Nursing Home Administrator/designee to ensure written notification was provided to resident and resident's responsible party regarding the reason for transfer weekly times three weeks then monthly times three months.  Results of these audits will be reviewed in Quality Assurance and Performance Improvement times four months or until substantial compliance is noted.  Facility transfers to acute care facilities/hospitals will be audited weekly times three weeks then monthly times three months by the	

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F 0628  SS=D	Continued from page 19  (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628	Nursing Home Administrator/designee to ensure resident's electronic medical record contains written documentation that the resident/resident's representative was notified via phone call or in person and received a written copy of facility bed-hold policy.  Results of these audits will be reviewed in Quality Assurance and Performance Improvement times four months or until substantial compliance is noted.  Nursing Home Administrator/designee will audit resident transfers to the hospital to ensure the Ombudsman was notified of the transfer weekly times three weeks then monthly times three months.  Results of these audits will be reviewed in Quality Assurance and Performance Improvement times four months or until substantial compliance is noted.	

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F 0628  SS=D	Continued from page 20  This REQUIREMENT is not met as evidenced by:	F 0628	Director of Nursing/designee will audit resident discharges to ensure a Physician Discharge Summary Form is completed weekly times six weeks then monthly times six months.  Results of these audits will be reviewed in Quality Assurance and Performance Improvement times eight months or until substantial compliance is noted.	

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F 0628  SS=D	Continued from page 21  Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and the resident's representative, in writing regarding the reason for transfer to the hospital, to ensure that a bed-hold notice was provided to the resident's responsible party and that the ombudsman was notified of the transfer to the hospital, for three of 35 residents reviewed (Residents 2, 19, 38), and failed to complete a post discharge summary for one of 35 resident's reviewed (Resident 37)  Findings include:  The facility's policy regarding bed-holds and returns, dated March 12, 2025, indicated that residents and/or representatives are informed (in writing) of the facility and bed-hold policies. An original is to be placed in the resident chart and one given to the family. The facility's policy regarding physician discharge summary revealed that when a resident is discharged the physician will complete and sign a	F 0628		

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F 0628  SS=D	Continued from page 22  discharge summary that includes the diagnosis, course of treatment, and pertinent test results.  A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated May 31, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included chronic obstructive pulmonary disease (a lung disease that causes decreased blood flow to the lungs).  A nurse's note for Resident 2, dated November 13, 2025, at 6:17 p.m., revealed that the resident was difficult to wake up, had an elevated blood pressure of 180/100 with a temperature of 96.3. She was pale, cold to the touch, and was catheterized for a distended bladder. Resident 2's BiPAP machine (a type of non-invasive ventilation device used to help with breathing difficulties) was placed on her, and she was sent to the hospital where she was admitted for acute (sudden onset) respiratory failure.	F 0628		

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F 0628  SS=D	Continued from page 23  There was no documented evidence that written notification of transfer was provided to Resident 2 and the resident's representative, that a bed-hold notice was provided to the resident's responsible party, and that the ombudsman was notified of the transfer to the hospital as required.  A quarterly MDS assessment for Resident 19, dated March 31, 2025, indicated that the resident was severely cognitively impaired, required assistance from staff for all daily care needs, and had a diagnoses that included Alzheimer's and Parkinson's disease and chronic obstructive pulmonary disease with a history of respiratory failure.  Nursing notes for Resident 19, dated November 5, 2025, at 6:05 p.m., revealed that the resident was grey in color, lethargic and difficult to arouse, she was immediately transferred to the hospital and was admitted.  There was no documented evidence that written	F 0628		

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F 0628  SS=D	Continued from page 24  notification of transfer was provided to the resident and the resident's representative, that a bed-hold notice was provided to the resident's responsible party, and no documented evidence that the ombudsman was notified of her transfer to the hospital as required.  An admission MDS assessment for Resident 38, dated March 21, 2025, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had diagnoses that included paraplegia with nerve damage to the bladder, acute and chronic respiratory failure, and pneumonia.  Nursing notes for Resident 38, dated March 22, 2025, at 9:00 p.m., indicated that the resident was complaining of difficulty breathing and was unable to maintain oxygen rates above 80 percent on room air. He was hard to arouse, had abnormal lung sounds, and a productive cough of thick white mucus. The resident was transferred to the hospital.	F 0628		

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F 0628  SS=D	Continued from page 25  A nursing note, dated March 23, 2025, at 3:02 a.m., indicated that Resident 38 was admitted to the hospital with a diagnosis of sepsis (a life threatening response to an infection).  There was no documented evidence that written notification of transfer was provided to the resident and the resident's representative, that a bed-hold notice was provided to the resident's responsible party, and no documented evidence that the ombudsman was notified of his transfer to the hospital as required.  Nursing notes for Resident 37 indicated that he was admitted on January 31, 2025, with a diagnosis of parapneumonic effusion (fluid accumulation in the space between the lung and chest wall accompanied by pneumonia). He received physical therapy/strengthening at the facility, and on April 7, 2025, he was discharged back to his previous residence at a personal care home.  There was no documented evidence that a discharge	F 0628		

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F 0628  SS=D	Continued from page 26  summary (an overview of the residents stay at the facility) was done by the physician as required.  Interview with the Director of Nursing on July 2, 2025, at 2:19 p.m. confirmed that for Residents 2, 19 and 38 there was no written notification of hospital transfer provided to them or their representatives, that a bed-hold notice was not provided to their responsible party, and that the ombudsman was not notified of the transfer to the hospital as required. In addition, the Director of Nursing confirmed that there was no documented discharge summary post discharge from the facility for Resident 37 as required.  28 Pa. Code 201.29(j) Resident Rights.	F 0628		
F 0636  SS=E		F 0636		

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F 0636  SS=E	Continued from page 27  483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 0636	Resident 14 no longer resides in the facility.  Resident 26 no longer resides in the facility.  Resident 34 was assessed with no noted concerns related to her May 26th Admission Minimum Data Set Assessment being completed on June 2, 2025, which was one day late.  Resident 43 was assessed with no noted concerns related to her May 7th Admission Minimum Data Set Assessment being completed on May 19, 2025, which was six days late.  Resident 44 no longer resides in the facility.  Resident 139 no longer resides in the facility.  Resident 140 no longer resides in the facility.  Resident 141 no longer resides in the	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
STATE LICENSE NUMBER: <b>09750201</b>				
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F 0636  SS=E	Continued from page 28  (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.  §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b) (2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months.  This REQUIREMENT is not met as evidenced by:	F 0636	facility.  Resident 142 no longer resides in the facility.  Resident 143 no longer resides in the facility.  Any resident admitted to the facility has the ability to be affected by this alleged deficient practice.  A whole house audit of recent resident admissions was completed to ensure the Admission Minimum Data Set Assessments were completed on time.  Nursing Home Administrator completed re-education with the Registered Nurse Assessment Coordinator and Licensed Practical Nurse Assessment Coordinator of the need to have Admission Minimum Data Set Assessments completed timely, no later than the resident's admission date plus thirteen calendar days as per the Long-Term Care Facility Resident	

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NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>  STATE LICENSE NUMBER: <b>09750201</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>
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F 0636  SS=E	Continued from page 29	F 0636	<p>Assessment Instrument User's Manual.</p> <p>Nursing Home Administrator/designee will audit Admission Minimum Data Set Assessments weekly times four weeks, monthly times three months.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement for results, areas of improvement and/or continuation of audits times four months or until substantial compliance is noted.</p>	

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NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
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F 0636  SS=E	Continued from page 30  Based on review of the Resident Assessment Instrument User's Manual and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive admission Minimum Data Set assessments were completed in the required timeframe for 10 of 35 residents reviewed (Residents 14, 26, 34, 43, 44, 139, 140, 141, 142, 143).  Findings include:  The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that for admission MDS assessments, the assessment completion date was to be no later than the resident's admission date plus 13 calendar days.  An admission Minimum Data Set (MDS)	F 0636		

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F 0636  SS=E	Continued from page 31  assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated May 12, 2025, revealed that the resident was admitted on May 5, 2025. The resident's MDS was documented in section Z0500B as being completed on May 19, 2025, which was one day late.  An admission MDS assessment for Resident 26, dated May 21, 2025, revealed that the resident was admitted on May 14, 2025. The resident's MDS was documented in section Z0500B as being completed on May 29, 2025, which was two days late.  An admission MDS assessment for Resident 34, dated May 26, 2025, revealed that the resident was admitted on May 19, 2025. The resident's MDS was documented in section Z0500B as being completed on June 2, 2025, which was one day late.  An admission MDS assessment for Resident 43, dated May 7, 2025, revealed that the resident was	F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>  STATE LICENSE NUMBER: <b>09750201</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
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F 0636  SS=E	Continued from page 32  admitted on April 30, 2025. The resident's MDS was documented in section Z0500B as being completed on May 19, 2025, which was six days late.  An admission MDS assessment for Resident 44, dated May 26, 2025, revealed that the resident was admitted on May 19, 2025. The resident's MDS was documented in section Z0500B as being completed on June 2, 2025, which was one day late.  An admission MDS assessment for Resident 139, dated April 23, 2025, revealed that the resident was admitted on April 16, 2025. The resident's MDS was documented in section Z0500B as being completed on May 1, 2025, which was two days late.  An admission MDS assessment for Resident 140, dated May 12, 2025, revealed that the resident was admitted on May 5, 2025. The resident's MDS was documented in section Z0500B as being	F 0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>	
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F 0636  SS=E	Continued from page 33  completed on May 19, 2025, which was one day late.  An admission MDS assessment for Resident 141, dated May 12, 2025, revealed that the resident was admitted on May 5, 2025. The resident's MDS was documented in section Z0500B as being completed on May 19, 2025, which was one day late.  An admission MDS assessment for Resident 142, dated May 18, 2025, revealed that the resident was admitted on May 12, 2025. The resident's MDS was documented in section Z0500B as being completed on May 29, 2025, which was four days late.  An admission MDS assessment for Resident 143, dated May 19, 2025, revealed that the resident was admitted on May 12, 2025. The resident's MDS was documented in section Z0500B as being completed on June 12, 2025, which was eight days late.	F 0636		

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F 0636  SS=E	Continued from page 34  Interview with the Licensed Practical Nurse Assessment Coordinator (LPNAC - a licensed practical nurse who is responsible for assisting the registered nurse with the completion of MDS assessments) on July 1, 2025, at 9:38 a.m. confirmed that the admission MDS assessments listed above were not completed within the required timeframes.  28 Pa. Code 211.5(f) Clinical Records.	F 0636		
F 0641  SS=D		F 0641		

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F 0641  SS=D	Continued from page 35  483.20(g)(h)(i)(j) Accuracy of Assessments  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	A Modification Request to correct the erroneous coding for Section N0415G1 for Resident 1 for the Annual Minimum Data Set Assessment dated May 24, 2025 was completed and submitted on July 15, 2025.  A Modification Request to correct the erroneous coding for Section N0415K1 for Resident 25 for the Significant Change Minimum Data Set Assessment dated April 22, 2025 was completed and submitted on July 2, 2025.  Residents who receive diuretic medications have the ability to be affected by this alleged deficient practice.  A whole house audit of recently completed Minimum Data Set Assessments was completed by the Director of Nursing/designee to ensure residents receiving diuretic medications were coded correctly on completed assessments.	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0641  SS=D	Continued from page 36  This REQUIREMENT is not met as evidenced by:	F 0641	Residents who receive anticonvulsant medications have the ability to be affected by this alleged deficient practice.  A whole house audit of recently completed Minimum Data Set Assessments was completed by the Director of Nursing/designee to ensure residents receiving anticonvulsant medications were coded correctly on completed assessments.  The Director of Nursing reviewed the coding instructions for Section N0415G1 in the Resident Assessment Instrument Manual with the Registered Nurse Assessment Coordinator and the Licensed Practical Nurse Assessment Coordinator.  The Director of Nursing reviewed the coding instructions for Section N0415K1 in the Resident Assessment Instrument Manual with the Registered Nurse Assessment	

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F 0641  SS=D	Continued from page 37	F 0641	<p>Coordinator and the Licensed Practical Nurse Assessment Coordinator.</p> <p>Audits will be performed by the Director of Nursing/designee weekly times four weeks then monthly times two months to ensure any resident receiving diuretic medications is coded correctly.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times three months or until substantial compliance is noted.</p> <p>Audits will be performed by the Director of Nursing/designee weekly times four weeks then monthly times two months to ensure any resident receiving anticonvulsant medications is coded correctly.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times three months or until substantial compliance is noted.</p>	

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F 0641  SS=D	Continued from page 38  Based on a 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 two of 35 residents reviewed (Residents 1, 25).  Findings include:  The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2024, revealed that Section N0415G1 Diuretic Medications was to be coded if the resident took the medication during the seven-day look-back period, and Section N0415K1 Anticonvulsant Medications was to be coded if the resident took the medication during the seven-day look-back period.  Physician's orders for Resident 1, dated May 21,	F 0641		

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F 0641  SS=D	Continued from page 39  2025, included an order for the resident to receive 20-25 milligram (mg) of Lisinopril-hydrochlorothiazide (a combination antihypertensive-diuretic medication used to lower blood pressure) in the morning for hypertension (high blood pressure).  Review of the Medication Administration Record (MAR) for Resident 1, dated May 2025, revealed that staff administered the 20-25 milligram (mg) of Lisinopril-hydrochlorothiazide every morning from May 21 through 31, 2025. However, an annual MDS assessment for Resident 1, dated, May 24, 2025, revealed that Section NO415G1 was not coded, indicating that the resident did not receive a diuretic medication during the seven-day look-back assessment period.  Physician's orders for Resident 25, dated October 28, 2022, included an order for the resident to receive 100 mg of Dilantin (an anticonvulsant) every morning and at bedtime for seizures.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0641  SS=D	Continued from page 40  Review of the Medication Administration Record (MAR) for Resident 25, dated April 2025, revealed that staff administered the 100 mg tablet of Dilantin to the resident every morning and every bedtime from April 1 through 30, 2025. However, a significant change MDS assessment for Resident 25, dated April 22, 2025, revealed that Section NO415K1 was not coded, indicating that the resident to did not receive an anticonvulsant medication during the seven-day look-back assessment period.  Interview with the Director of Nursing on July 1, 2025, at 1:09 p.m. confirmed the Resident 1 and 25's MDS assessments listed above were coded incorrectly.  28 Pa. Code 211.5(f) Clinical Records.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0656  SS=D		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0656  SS=D	Continued from page 42  483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Resident 9's comprehensive care plans were updated to reflect her care needs related to her use of anticoagulant, antiplatelet and diuretic medications.  Any resident who uses anticoagulant medications has the ability to be affected by this alleged deficient practice.  A whole house audit on residents who use anticoagulant medications was completed to ensure that an individualized written plan of care was developed and in place for these residents addressing their care needs related to their anticoagulant use.  Any resident who uses antiplatelet medications has the ability to be affected by this alleged deficient practice.  A whole house audit on residents who use antiplatelet medications was completed to ensure that an individualized written plan of care	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
STATE LICENSE NUMBER: <b>09750201</b>				
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F 0656  SS=D	Continued from page 43  discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.  This REQUIREMENT is not met as evidenced by:	F 0656	was developed and in place for these residents addressing their care needs related to their antiplatelet use.  Any resident who uses diuretic medications has the ability to be affected by this alleged deficient practice.  A whole house audit on residents who use diuretic medications was completed to ensure that an individualized written plan of care was developed and in place for these residents addressing their care needs related to their diuretic use.  Licensed Nursing Staff, including Agency Licensed Staff, re-educated on the importance of creating an individualized, person-centered plan of care for residents including care needs for residents who use anticoagulant medications, who use antiplatelet medications and who use diuretic medications.  Interdisciplinary Care Plan Team will	

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F 0656  SS=D	Continued from page 44	F 0656	<p>continue to review care plans upon resident admissions, at regularly scheduled care plan conferences and as needed to ensure individualized, person-centered care needs are included and up to date.</p> <p>The Director of Nursing/designee will audit care plans for residents who use anticoagulant medications, who use antiplatelet medications and who use diuretic medications to be sure these medications are addressed in their care plans weekly times ten weeks and then monthly times four months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times seven months or until substantial compliance is noted.</p>	

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F 0656  SS=D	Continued from page 45  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 one of 35 residents reviewed (Resident 9).  Findings include:  A facility policy for Care Plans, dated March 12, 2025, indicated that the resident and his or her representative were encouraged to participate in the development and implementation of the resident's person-centered care plan.  A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 9, dated April 10, 2025, revealed that the resident was cognitively intact, required extensive assistance from staff with daily care tasks, and received an anticoagulant, antiplatelet, and diuretic medication.	F 0656		

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F 0656  SS=D	Continued from page 46  Physician's orders for Resident 9, dated September 9, 2024, included an order for the resident to receive 5 milligrams (mg) of Apixaban (anticoagulant-used to prevent blood clots) by mouth every morning and bedtime, 81 mg of Aspirin (antiplatelet) by mouth daily in the morning, and 20 mg of Lasix (diuretic) by mouth daily in the morning.  There was no documented evidence that a care plan was developed to address Resident 9's individual care and treatment needs related to her use of anticoagulant, antiplatelet, and diuretic medications.  Interview with the Director of Nursing on July 1, 2025, at 1:15 p.m. confirmed that a care plan to address the care needs related to Resident 9's need for anticoagulant, antiplatelet, and diuretic medication use was not developed and should have been.  28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0656		

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F 0657  SS=E		F 0657		

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F 0657  SS=E	Continued from page 48  483.21(b)(2)(i)-(iii) Care Plan Timing and Revision  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.  This REQUIREMENT is not met as evidenced by:	F 0657	Resident 13's care plan was revised/updated to reflect her bladder incontinence since removal of her indwelling urinary catheter on April 15, 2025.  Any resident who has their indwelling urinary catheter removed has the ability to be affected by this alleged deficient practice.  A whole house audit of residents recently having their indwelling urinary catheter removed was completed to ensure his/her care plan has been revised to reflect their current bladder continence/incontinence status.  Licensed nursing staff, including agency licensed nursing staff, re-educated on the importance of updating/revising resident care plans to reflect resident specific care needs including residents who have their indwelling urinary catheter removed to include his/her bladder continence/incontinence status in the care plan.	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0657  SS=E	Continued from page 49	F 0657	<p>Licensed Practical Nurse Assessment Coordinator will routinely review order summary reports to ensure resident care plans are updated/revised with changes, new orders and/or discontinued orders that reflect a change to resident's current plan of care.</p> <p>Interdisciplinary Care Plan Team will continue to review care plans upon resident admissions, at regularly scheduled care plan conferences and as needed to ensure individualized, person-centered care needs are included and up to date in resident care plans.</p> <p>The Director of Nursing/designee will audit care plans for residents who have had their indwelling urinary catheter removed weekly times twelve weeks and then monthly times four months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of</p>	

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F 0657  SS=E	Continued from page 50	F 0657	<p>audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times seven months or until substantial compliance is noted.</p> <p>Licensed Practical Nurse Assessment Coordinator/designee will conduct random audits of resident care plans to ensure that all person-centered care needs are included/updated to reflect the resident current care needs weekly times fifteen weeks and then monthly times four months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times eight months or until substantial compliance is noted.</p>	

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F 0657  SS=E	Continued from page 51  Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for one of 35 residents reviewed (Resident 13).  Findings include:  The facility's policy regarding care plans, dated March 12, 2025, indicated that each resident will have an individualized interdisciplinary plan of care in place. The comprehensive care plan will be reviewed and revised on a quarterly basis, with a significant change in condition, on re-admission, and as needed or requested by the resident and/or resident's representative.  A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 13, dated April 9, 2025, revealed that the resident was understood, could understand others, and had	F 0657		

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F 0657  SS=E	Continued from page 52  diagnoses that included obstructive uropathy (a condition where there is a blockage in the urinary tract, preventing normal urine flow). A care plan for the resident, dated February 11, 2025, revealed that the resident had an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine); however, on April 16, 2025, the care plan was resolved due to the resident not requiring to have an indwelling urinary catheter any longer.  Physician's orders for Resident 13, dated April 15, 2025, included an order for staff to discontinue the use of the resident's indwelling urinary catheter.  Review of Resident 13's clinical record including nurse aide documentation revealed that the resident has frequently been incontinent of bladder. However, as of July 2, 2025, there was no documented evidence that Resident 13's care plan was revised/updated to reflect that the resident was incontinent of bladder since the removal of her indwelling urinary catheter on April 15, 2025.	F 0657		

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F 0657  SS=E	Continued from page 53  Interview with the Director of Nursing on July 2, 2025, at 8:44 a.m. confirmed that there was no documented evidence that Resident 13's care plan was revised/updated to reflect that the resident was incontinent of bladder, since the removal of her indwelling urinary catheter on April 15, 2025.  28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0684  SS=D		F 0684		

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F 0684  SS=D	Continued from page 54  483.25 Quality of Care  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  This REQUIREMENT is not met as evidenced by:	F 0684	Resident 12 assessed with no noted concerns related to her receiving only 19 of the 21 doses of meropenem intravenously over seven days as ordered by the physician on May 20, 2025.  Resident 12's physician notified of meropenem being administered intravenously for only 19 out of 21 doses from May 22, 2025 through May 28, 2025.  Any resident with a physician order for intravenous antibiotics has the ability to be affected by this alleged deficient practice.  A whole house audit on residents with physician orders for intravenous antibiotics was completed to ensure the correct number of doses was administered to the resident as per the physician orders.  Licensed nursing staff, including agency licensed nursing staff, re-educated to administer	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0684  SS=D	Continued from page 55	F 0684	<p>intravenous antibiotics to residents as per physician orders for the correct number of specified doses.</p> <p>The Director of Nursing/designee will audit medication administration records of residents who are to receive/receiving/received intravenous antibiotics to ensure resident is administered/receives the correct number of doses as per the physician orders weekly times eight weeks and then monthly times three months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times five months or until substantial compliance is noted.</p>	

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F 0684  SS=D	Continued from page 56  Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for one of 35 residents reviewed (Resident 12).  Findings include:  A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated June 20, 2025, revealed that the resident was understood, and could usually understand others.  Physician's orders for Resident 12, dated May 20, 2025, included an order for the resident to receive one gram (gm) of Meropenem (an antibiotic to treat a variety of serious bacterial infections) intravenously (a medical process that administers fluids, medications and nutrients directly into a person's	F 0684		

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F 0684  SS=D	Continued from page 57  vein) every eight hours for a urinary tract infection for seven days (a total of 21 doses).  Review of Resident 12's Medication Administration Records (MARs) for May 2025 revealed that staff documented as administering the one gm of Meropenem intravenously on May 22 at 2:00 p.m. and 10:00 p.m.; May 23 through May 27 at 6:00 a.m., 2:00 p.m. and 10:00 p.m.; and on May 28 at 6:00 a.m. and 2:00 p.m. (total of 19 doses).  Interview with the Director of Nursing on July 2, 2025, at 10:45 a.m. confirmed that Resident 12 only received 19 of the 21 doses of IV Meropenem over seven days as ordered by the physician.  28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0684		
F 0689  SS=D		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
STATE LICENSE NUMBER: <b>09750201</b>				
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F 0689  SS=D	Continued from page 58  483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:	F 0689	Resident 9's bilateral fall mats were immediately placed on each side of her bed while she was in bed.  Resident 9 was assessed with no noted concerns related to her not having her bilateral fall mats on each side of her bed while she was in bed.  Any resident with the fall/injury prevention intervention of fall mat/mats has the ability to be affected by this alleged deficient practice.  A whole house audit on residents with the fall/injury prevention intervention of fall mat/mats was completed to ensure the fall mat/mats were correctly in place.  Direct care staff, including agency direct care staff, were re-educated on the importance of ensuring fall/injury prevention interventions are in place, including fall mat/mats, as care planned.  The Director of Nursing/designee	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>  STATE LICENSE NUMBER: <b>09750201</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>
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F 0689  SS=D	Continued from page 59	F 0689	<p>will conduct audits of residents care planned to have a fall mat/fall mats for fall/injury prevention weekly times eight weeks and then monthly times four months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times six months or until substantial compliance is noted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>  STATE LICENSE NUMBER: <b>09750201</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
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F 0689  SS=D	Continued from page 60  Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as possible by failing to ensure that fall/injury prevention interventions were in place for one of 35 residents reviewed (Resident 9).  Findings include:  A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 9, dated April 10, 2025, revealed that the resident was cognitively intact, required extensive assistance from staff with daily care tasks, and had limited range of motion to her lower extremities. The resident's care plan, dated June 19, 2025, revealed that the resident was at risk for falls and indicated that fall mats were to be at bedside.  A nursing note for Resident 9, dated June 13, 2025, at 2:50 a.m., revealed that the resident was found	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
STATE LICENSE NUMBER: <b>09750201</b>				
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F 0689  SS=D	Continued from page 61  lying on the floor on the left side of her bed. New interventions included placing her bed in the lowest position and bilateral fall mats.  Observations of Resident 9 on July 2, 2025, at 8:46 a.m. revealed that the resident was in bed and there were no fall mats on either side of her bed.  Interview with the Director of Nursing on July 2, 2025, at 11:54 a.m. confirmed that Resident 9 should have had bilateral fall mats while in bed.  28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0689		
F 0690  SS=E		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0690  SS=E	Continued from page 62  483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.  §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Resident 1 was assessed with no ill effects and/or noted concerns related to her not having her urine output documented on the first shift (0600 to 1430) on May 13, 2025; June 11, 2025; June 14, 2025; June 16, 2025 and June 20, 2025; on the second shift (1400 to 2230) on May 21, 2025; June 9, 2025 and June 20, 2025 and on the third shift (2200 to 0630) on June 6, 2025 and June 30, 2025.  Resident 1's physician notified of resident not having her urine output documented on the first shift (0600 to 1430) on May 13, 2025; June 11, 2025; June 14, 2025; June 16, 2025 and June 20, 2025; on the second shift (1400 to 2230) on May 21, 2025; June 9, 2025 and June 20, 2025 and on the third shift (2200 to 0630) on June 6, 2025 and June 30, 2025.  Resident 13 was assessed with no ill effects and/or noted concerns related to her not having her bladder continence/incontinence documented on May 14, 2025 at 0800 1000 and 1200; May 15, 2025 at 0800,	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>  STATE LICENSE NUMBER: <b>09750201</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
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F 0690  SS=E	Continued from page 63  This REQUIREMENT is not met as evidenced by:	F 0690	<p>1000 and 1200; May 17, 2025 at 0800, 1000 and 1200; May 24, 2025 at 0800, 1000 and 1200; May 25, 2025 at 0000, 0200 and 0400; June 4, 2025 at 0000, 0200 and 0400; June 5, 2025 at 0000, 0200 and 0400; June 6, 2025 at 0800, 1000 and 1200; June 10, 2025 at 0800, 1000 and 1200; June 11, 2025 at 0800, 1000 and 1200; June 13, 2025 at 0000, 0200 and 0400; June 15, 2025 at 0800, 1000, 1200, 1400, 1600, 1800 and 2000; and June 25, 2025 at 0800, 1000 and 1200.</p> <p>Resident 13's physician was notified of resident not having her bladder continence/incontinence documented on May 14, 2025 at 0800 1000 and 1200; May 15, 2025 at 0800, 1000 and 1200; May 17, 2025 at 0800, 1000 and 1200; May 24, 2025 at 0800, 1000 and 1200; May 25, 2025 at 0000, 0200 and 0400; June 4, 2025 at 0000, 0200 and 0400; June 5, 2025 at 0000, 0200 and 0400; June 6, 2025 at 0800, 1000 and 1200; June 10, 2025 at 0800, 1000 and 1200; June 11, 2025 at 0800, 1000 and 1200; June 13, 2025 at 0000, 0200 and 0400; June 15, 2025 at 0800,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0690  SS=E	Continued from page 64	F 0690	<p>1000, 1200, 1400, 1600, 1800 and 2000; and June 25, 2025 at 0800, 1000 and 1200.</p> <p>Resident 13 was assessed with no ill effects and/or noted concerns related to her not having any documented evidence of her barrier cream being applied to her buttocks during the day shift on May 1, 2025; May 15, 2025; May 17, 2025; May 24, 2025 and May 26, 2025; during the evening shift on May 1, 2025; May 2, 2025; June 3, 2025 and June 15, 2025 and during the night shift on May 24, 2025; May 31, 2025; June 2, 2025; June 3, 2025; June 4, 2025 and June 12, 2025.</p> <p>Resident 13's physician notified of resident not having any documented evidence of her barrier cream being applied to her buttocks during the day shift on May 1, 2025; May 15, 2025; May 17, 2025; May 24, 2025 and May 26, 2025; during the evening shift on May 1, 2025; May 2, 2025; June 3, 2025 and June 15, 2025 and during the night shift on</p>	

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F 0690  SS=E	Continued from page 65	F 0690	<p>May 24, 2025; May 31, 2025; June 2, 2025; June 3, 2025; June 4, 2025 and June 12, 2025.</p> <p>Any resident who has an indwelling urinary catheter has the ability to be affected by this alleged deficient practice.</p> <p>A whole house audit of residents having an indwelling urinary catheter was completed to ensure his/her urinary output has been monitored and documented in the resident's medical record/electronic medical record every shift.</p> <p>Any resident who has a nurse aide task to document resident's bladder continence/incontinence every two hours has the ability to be affected by this alleged deficient practice.</p> <p>A whole house audit of residents having a nurse aide task to document resident's bladder continence/incontinence every two hours was completed to ensure his/her documentation of bladder</p>	

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F 0690  SS=E	Continued from page 66	F 0690	<p>continence/incontinence has been monitored and documented in the resident's medical record/electronic medical record every two hours.</p> <p>Any resident who has a nurse aide task to document application of resident's barrier cream has the ability to be affected by this alleged deficient practice.</p> <p>A whole house audit of residents having a nurse aide task to document application of resident's barrier cream was completed to ensure documentation of application of barrier cream was present in his/her Point Click Care - Point of Care electronic record.</p> <p>Direct care staff, including agency direct care staff, were re-educated on the facility's Urinary Output Policy, including the importance of ensuring urinary output is monitored and documented every shift in the medical record for residents who have indwelling urinary catheters.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0690  SS=E	Continued from page 67	F 0690	<p>Direct care staff, including agency direct care staff, were re-educated on the importance of monitoring residents' bladder continence/incontinence frequently throughout the shift and documenting in Point Click Care - Point of Care as per scheduled task, including tasks scheduled every two hours.</p> <p>Direct care staff, including agency direct care staff, were re-educated on the importance of applying barrier cream to residents and documenting the application of the applied barrier cream in the resident's electronic medical record/Point Click Care - Point of Care as per his/her scheduled task.</p> <p>The Director of Nursing/designee will audit documentation of urinary output of residents who have an indwelling urinary catheter weekly times fifteen weeks and then monthly times six months and then reviewed by the Quality Assurance Performance Improvement</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0690  SS=E	Continued from page 68	F 0690	<p>Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times ten months or until substantial compliance is noted.</p> <p>The Director of Nursing/designee will conduct random audit Point Click Care - Point of Care task documentation of bladder continence/incontinence weekly times fifteen weeks and then monthly times six months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times ten months or until substantial compliance is noted.</p>	

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F 0690  SS=E	Continued from page 69	F 0690	<p>The Director of Nursing/designee will conduct random audit Point Click Care - Point of Care task documentation of resident barrier cream applications weekly times fifteen weeks and then monthly times six months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times ten months or until substantial compliance is noted.</p>	

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F 0690  SS=E	Continued from page 70  Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure urinary output was monitored for one of 35 residents reviewed (Resident 1) who had an indwelling urinary catheter, and failed to ensure proper incontinent care was completed for one of 35 residents reviewed (Resident 13).  Findings include:  The facility's policy regarding urinary output, dated March 12, 2025, revealed that the volume of urine output was to be documented in the resident's chart or electronic medical record.  An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 24, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care tasks, had an indwelling urinary catheter (a tube inserted	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>	
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F 0690  SS=E	Continued from page 71  and held in the bladder to drain urine), and had diagnoses that included neurogenic bladder (a lack of bladder control due to a brain, spinal cord, or nerve condition). Physician's orders for Resident 1, dated May 26, 2025, included orders for a Foley catheter for neurogenic bladder. A care plan, dated June 24, 2024, revealed that staff were to monitor and document the resident's intake and output.  Nurse Aide documentation for Resident 1, dated May and June 2025, revealed that staff was to document the resident's urine output each shift; however, there was no documented evidence that urine output was recorded on the first shift (6:00 a.m. to 2:30 p.m.) on May 13, June 11, 14, 16, and 20, 2025; on the second shift (2:00 p.m. to 10:30 p.m.) on May 21, June 9 and 20, 2025; and on the third shift (10:00 p.m. to 6:30 a.m.) on June 6 and 30, 2025.  Interview with the Director of Nursing on July 2, 2025, at 10:23 a.m. confirmed that there was no urine output recorded for Resident 1 on the	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
STATE LICENSE NUMBER: <b>09750201</b>				
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F 0690  SS=E	Continued from page 72  mentioned dates and times.  A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 13, dated April 9, 2025, revealed that the resident was understood and could understand others. A care plan for the resident, dated September 26, 2023, revealed that the resident had an Activities of Daily Living (ADL) self-care deficit related to her limited mobility, and that she required the assist of two staff with toileting.  Nurse Aide tasks for Resident 13, for May and June 2025, revealed that staff was to document every two hours to indicate if the resident was continent or incontinent of bladder; however, there was no evidence that bladder continence or incontinence was documented on May 14 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.; May 15 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.; May 17 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.; May 24 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.; May 25 at 12:00	F 0690		

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F 0690  SS=E	Continued from page 73  a.m., 2:00 a.m., and 4:00 a.m.; June 4 at 12:00 a.m., 2:00 a.m., and 4:00 a.m.; June 5 at 12:00 a.m., 2:00 a.m., and 4:00 a.m.; June 6 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.; June 10 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.; June 11 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.; June 13 at 12:00 a.m., 2:00 a.m., and 4:00 a.m.; June 15 at 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., and 8:00 p.m.; and June 25 at 8:00 a.m., 10:00 a.m., and 12:00 p.m.  Nurse Aide tasks for Resident 13, for May and June 2025, revealed that staff was to document the application of barrier cream to the resident's buttocks; however, there was no documented evidence that staff applied the barrier cream to the resident's buttocks during the day shift on May 1, 15, 17, 24, and 26, 2025; during evening shift on May 1, and 2, 2025, and on June 3 and 15, 2025; and during the night shift on May 24, and 31, 2025, and on June 2, 3, 4, and 12, 2025.  Interview with the Director of Nursing on July 1,	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0690  SS=E	Continued from page 74  2025, at 1:38 p.m. confirmed that there was no documented evidence that Resident 13's bladder continence or incontinence was documented on the above dates and times, and that application of barrier cream to the resident's buttocks was applied on the above dates.  28 Pa. Code 211.12(d)(5) Nursing Services.	F 0690		
F 0694  SS=E		F 0694		

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F 0694  SS=E	Continued from page 75  483.25(h) Parenteral/IV Fluids  § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.  This REQUIREMENT is not met as evidenced by:	F 0694	Resident 9 assessed with no noted concerns related to having no documented evidence that her peripheral intravenous catheter was flushed with normal saline solution before and after the administration of her physician-ordered meropenem doses on April 10, 2025 through April 16, 2025.  Resident 9's physician was notified regarding the facility having no documented evidence that her peripheral intravenous catheter was flushed with normal saline solution before and after her meropenem doses administered on April 10, 2025 through April 16, 2025.  Resident 12 assessed with no noted concerns related to having no physician orders regarding care and maintenance of her midline May 22, 2025 through May 29, 2025, and related to having no documented evidence that her midline was flushed with normal saline solution before and after the administration of her	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0694  SS=E	Continued from page 76	F 0694	<p>physician-ordered meropenem doses May 22, 2025 through May 29, 2025.</p> <p>Resident 12's physician was notified regarding the facility having no physician orders regarding care and maintenance of her midline May 22, 2025 through May 29, 2025. and related to having no documented evidence that her midline was flushed with normal saline solution before and after the administration of her physician-ordered meropenem doses May 22, 2025 through May 29, 2025.</p> <p>Any resident receiving intravenous medications via a peripheral intravenous catheter has the ability to be affected by this alleged deficient practice.</p> <p>A whole house audit completed for residents with intravenous catheters to ensure physician orders and documentation present for flushing the intravenous catheter with saline routinely, including before and after the administration of intravenous</p>	

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F 0694  SS=E	Continued from page 77	F 0694	<p>medication as per his/her physician order.</p> <p>Any resident having a midline has the ability to be affected by this alleged deficient practice.</p> <p>A whole house audit completed for residents with midlines to ensure physician orders were obtained for the care and maintenance of the resident's midline.</p> <p>Any resident receiving intravenous medications via a midline has the ability to be affected by this alleged deficient practice.</p> <p>A whole house audit completed for residents with a midline to ensure physician orders and documentation present for flushing the midline before and after the administration of intravenous medication as per his/her physician order.</p> <p>Licensed nursing staff, including agency licensed nursing staff, were re-educated on the facility Peripheral</p>	

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F 0694  SS=E	Continued from page 78	F 0694	<p>Intravenous Access Flushing Policy and the facility Peripheral Intravenous Access Medication Administration Policy, including the importance of obtaining a physician order for routine saline flushing and saline flushing prior to and following the administration of intravenous medications.</p> <p>Licensed nursing staff, including agency licensed nursing staff, were re-educated on the facility Peripherally Inserted Central Catheter Line and Midline Maintenance and Care Policy and the facility Peripherally Inserted Central Catheter Line and Midline Access Medication Administration Policy, including the importance of obtaining a physician order for routine saline flushing and saline flushing prior to and following the administration of intravenous medications.</p> <p>Registered Nurse Charge Nurse/Designee will audit residents receiving intravenous medications</p>	

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F 0694  SS=E	Continued from page 79	F 0694	<p>via a peripheral intravenous catheter to ensure physician orders are present for routine saline flushes as well as saline flushes before and after intravenous medication administrations three times per week times eight weeks then monthly until resolved.</p> <p>Findings from audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at its regularly scheduled meetings times three for results, areas of improvement and/or continuation of audits.</p> <p>Registered Nurse Charge Nurse/Designee will audit residents receiving intravenous medications via a peripheral intravenous catheter to ensure documentation is present on the resident's administration record for routine saline flushes as well as saline flushes before and after intravenous medication administrations three times per week times eight weeks then monthly until</p>	

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F 0694  SS=E	Continued from page 80	F 0694	<p>resolved.</p> <p>Findings from audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at its regularly scheduled meetings times three for results, areas of improvement and/or continuation of audits.</p> <p>Registered Nurse Charge Nurse/Designee will audit residents receiving intravenous medications via a midline catheter to ensure physician orders are present for routine saline flushes as well as saline flushes before and after intravenous medication administrations three times per week times eight weeks then monthly until resolved.</p> <p>Findings from audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at its regularly scheduled meetings times three for</p>	

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F 0694  SS=E	Continued from page 81	F 0694	<p>results, areas of improvement and/or continuation of audits.</p> <p>Registered Nurse Charge Nurse/Designee will audit residents receiving intravenous medications via a midline catheter to ensure documentation is present on the resident's administration record for routine saline flushes as well as saline flushes before and after intravenous medication administrations three times per week times eight weeks then monthly until resolved.</p> <p>Findings from audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at its regularly scheduled meetings times three for results, areas of improvement and/or continuation of audits.</p>	

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F 0694  SS=E	Continued from page 82  Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that intravenous catheters were flushed according to facility policy and failed to ensure that physician's orders for the care and maintenance of intravenous catheters were obtained for two 35 residents reviewed (Residents 9, 12).  Findings include:  The facility's policy regarding midline (a thin, flexible tube inserted into a large vein in the upper arm to administer medication or fluids intravenously) maintenance and care, dated March 12, 2025, indicated that staff was to change the transparent dressing every week or as needed if soiled, damp and/or loose. Staff was flush the line according to the physician's orders.  The policy regarding flushing the peripheral intravenous access (the insertion of a short, flexible catheter into a peripheral vein, typically in the hand	F 0694		

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F 0694  SS=E	Continued from page 83  or arm, to deliver medications, fluids or other therapies directly into the bloodstream), dated March 12, 2025, indicated that the following regimen should be used when flushing an intravenous catheter: Normal Saline flush (used to help prevent IV catheters from becoming blocked and also to help remove any medication that may be left at the catheter site), administration of medications or fluids, Normal Saline flush, and then Heparin flush (a medication used to maintain the openness of intravenous catheters) if ordered.  A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 9, dated April 10, 2025, revealed that the resident was cognitively intact, had a multi-drug resistant organism (bacteria that is resistant to multiple antibiotics), received an antibiotic, and had IV access.  Physician's orders for Resident 9, dated April 10, 2025, included an order for the resident to receive 500 milligrams (mg) of Meropenem intravenously	F 0694		

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F 0694  SS=E	Continued from page 84  every shift for a urinary tract infection for 20 administrations, and 10 milliliters (mL) of Sodium Chloride 0.9 percent intravenously for a routine flush every shift.  Review of Medication Administration Records (MARs) for Resident 9, dated April 2025, revealed that staff documented administering the 500 mg of Meropenem intravenously every shift from April 10, 2025, at 6:00 a.m. through April 16, 2025, at 2:00 p.m. However, there was no documented evidence that staff flushed Resident 9's peripheral IV with Normal Saline solution before and after the administration of the Meropenem.  Interview with the Director of Nursing on July 2, 2025, at 10:42 a.m. confirmed that there was no documented evidence that Resident 9's IV was flushed with Normal Saline solution before and after the administration of the Meropenem on the above dates.	F 0694		

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F 0694  SS=E	Continued from page 85  Physician's orders for Resident 12, dated May 20, 2025, included an order for the resident to receive one gram (gm) of Meropenem (an antibiotic to treat a variety of serious bacterial infections) intravenously (a medical process that administers fluids, medications and nutrients directly into a person's vein) every eight hours for a urinary tract infection for seven days.  A nursing note for Resident 12, dated May 22, 2025, revealed that the resident's midline was placed in her upper right arm without difficulty. A nursing note for Resident 12, dated May 29, 2025, revealed that the resident's right upper arm midline was removed with no complications. There was no documented evidence that Resident 12's physician was contacted for orders regarding the care and maintenance of the resident's midline from May 22 through 29, 2025, when it was removed.  Review of Medication Administration Records (MARs) for Resident 12, dated May 2025, revealed that staff documented as administering the	F 0694		

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F 0694  SS=E	Continued from page 86  one gm of Meropenem intravenously on May 22, 2025, at 2:00 p.m. and 10:00 p.m.; May 23 through May 27, 2025, at 6:00 a.m., 2:00 p.m. and 10:00 p.m.; and on May 28, 2025, at 6:00 a.m. and 2:00 p.m. However, there was no documented evidence that staff flushed Resident 12's midline with Normal Saline solution before and after the administration of the Meropenem.  Interview with the Director of Nursing on July 2, 2025, at 10:42 a.m. confirmed that there was no documented evidence that Resident 12's physician was contacted for orders regarding the care and maintenance of the resident's midline from May 22 through 29, 2025, when it was removed, and that there was no documented evidence that the resident's midline was flushed with Normal Saline solution before and after the administration of the Meropenem on the above dates.  28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0694		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>  STATE LICENSE NUMBER: <b>09750201</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>
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F 0755  SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0755  SS=D	Continued from page 88  483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-  §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.  §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and  §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Resident 25 assessed with no noted concerns with his pain and/or his pain medications.  Any resident having a physician order to receive a narcotic pain patch has the ability to be affected by this alleged deficient practice.  A whole house facility audit completed to ensure the Controlled Drug Count Records of residents who recently received narcotic pain patches have recorded documentation of two licensed nurse witness signatures for the destruction of the narcotic pain patches when removed from these residents.  Licensed nursing staff, including agency licensed nursing staff, were re-educated on the facility Narcotic and Controlled Substance Policy and Procedure regarding maintaining accountability for controlled medications, including the importance of witnessing and recording the destruction of any	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0755  SS=D	Continued from page 89  This REQUIREMENT is not met as evidenced by:	F 0755	<p>narcotic by two licensed nurses on the resident's Controlled Drug Record, including the removal of narcotic pain patches.</p> <p>Director of Nursing/Designee will complete random audits of residents receiving narcotic pain patches including Fentanyl, to ensure accurate documentation of the witnessing and recording of the witnessed destruction of the narcotic pain patch by two licensed nurses on the resident's Controlled Drug Record when the patch was removed weekly times twelve weeks then monthly times six months until noted substantial compliance. The Director of Nursing will conduct a thorough investigation of audit findings of any noted discrepancies and/or missing witness documentation of narcotic/controlled medication destruction to rule out any resident misappropriation and to ensure narcotic/controlled drug medication accountability.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0755  SS=D	Continued from page 90	F 0755	Findings from audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at its regularly scheduled meetings times nine months for results, areas of improvement and/or continuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>	
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F 0755  SS=D	Continued from page 91  Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 35 residents reviewed (Resident 25).  Findings include:  The facility's policy regarding disposal of narcotics, dated March 12, 2025, indicated that controlled/narcotic medications were to be destroyed in the presence of tow licensed nurses. The two nurses would count together the remaining amount of controlled/narcotic medications to be destroyed. Two nurses would sign and date the Control Drug Record upon witnessing the destruction of the controlled/narcotic medications, logging the amount of medications destroyed.  A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0755  SS=D	Continued from page 92  April 22, 2025, revealed that the resident was cognitively impaired, received pain medication routinely and as needed, and received an opioid (a controlled pain medication). Physician's orders, dated April 18, 2025, included an order for the resident to receive a 12 micrograms (mcg) Fentanyl (a narcotic pain patch) patch to be applied every three days for chronic pain, and physician's orders, dated May 22, 2025, included an order for the resident to receive a 25 mcg Fentanyl patch to be applied every three days for chronic pain.  Review of Resident 25's Medication Administration Record (MAR) for May and June 2025 revealed that a Fentanyl patch was applied to the resident on May 3, 6, 9, 12, 15, 18, 21, 25, 28, and 31, and June 3, 6, 9, 12, 15, 18, and 21, 2025.  A controlled drug count record (tracks each dose of a controlled medication) for Resident 25's Fentanyl patches revealed that one patch was signed out on the controlled drug log on May 3, 6, 9, 12, 15, 18, 21, 25, 28, and 31, and June 3, 6, 9, 12, 15, 18,	F 0755		

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F 0755  SS=D	Continued from page 93  21, 2025. There was no documented evidence that two staff members signed that the old patch was destroyed after removal on these dates.  Interview with the Director of Nursing on July 2, 2025, at 9:06 a.m. confirmed that there were not two witness signatures for the destruction of Fentanyl patches on the dates listed above.  28 Pa. Code 211.9(a)(h) Pharmacy Services.  28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0755		
F 0812  SS=F		F 0812		

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F 0812  SS=F	Continued from page 94  483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.  This REQUIREMENT is not met as evidenced by:	F 0812	Opened, unlabeled food items in the dry storage room, the kitchen refrigerator and the kitchen were immediately discarded.  Any resident admitted to the facility who receives a meal has the ability to be affected by this alleged deficient practice.  A baseline audit of food stored in the dry storage room and in the kitchen has been completed to ensure any opened food item has been labeled with an open date.  Dietary Manager re-educated dietary staff that food items stored in the dry storage area, in the kitchen and in the kitchen refrigerator are to be labeled with an open date upon opening of the food item.  The Dietary Manager/designee will audit the dry storage area, the kitchen and the kitchen refrigerator to ensure open food items are labeled with an open date weekly times six weeks and then monthly	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0812  SS=F	Continued from page 95	F 0812	<p>times four months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.</p> <p>Results of these audits will be reviewed in Quality Assurance and Performance Improvement times six months or until substantial compliance is noted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>	
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F 0812  SS=F	Continued from page 96  Based on facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that food stored in the kitchen and dry storage room was dated once opened.  Findings include:  The facility policy regarding food storage, dated March 12, 2025, revealed that any food item once opened should be labeled with an open date.  Observations in the dry storage room on June 30, 2025, at 8:53 a.m. revealed that there was one 10-pound bag of pasta that was opened and not dated with an open date.  Observations in the kitchen refrigerator on June 30, 2025, at 9:01 a.m. revealed two opened and undated 5-pound bags of cheese, one with parmesan and the other with a mixture of cheddar and mozzarella.	F 0812		

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F 0812  SS=F	Continued from page 97  Observations in the kitchen on June 30, 2025, at 9:07 a.m. revealed that there was approximately ten pounds of flour and twenty-five pounds of rice that were opened and not labeled with an open date.  Interview with the Dietary Manager and Director of Nursing on June 30, 2025, at 8:45 a.m. and 11:32 a.m. respectively, confirmed that all open food items in the kitchen should be labeled with a date once they are opened.  28 Pa. Code 211.6(f) Dietary Services.	F 0812		
F 0849  SS=D		F 0849		

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F 0849  SS=D	Continued from page 98  483.70(n)(1)-(4) Hospice Services  §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	Resident 25's updated hospice nurse aide and updated hospice Registered Nurse charting was immediately placed into the hospice provider's clinical record.  Any resident receiving hospice services has the ability to be affected by this alleged deficient practice.  A baseline audit of residents receiving hospice services has been completed to ensure updated hospice personnel charting is present and available in the hospice provider's clinical record.  Director of Nursing re-educated hospice providers regarding the importance of and the need for updated charting documentation to be timely placed into the resident's hospice provider's clinical chart consistently.  The Director of Nursing/designee will audit residents receiving hospice services for the presence of timely	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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F 0849  SS=D	Continued from page 99  (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	documentation of hospice providers' charting in the resident's hospice provider's clinical chart weekly times three weeks and then monthly times two months and then reviewed by the Quality Assurance Performance Improvement Committee for results, areas of improvement and/or continuation of audits.  Results of these audits will be reviewed in Quality Assurance and Performance Improvement times three months or until substantial compliance is noted.	

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F 0849  SS=D	Continued from page 100  drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.  §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849  SS=D	Continued from page 101  capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849  SS=D	Continued from page 102  orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.  §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.  This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849  SS=D	Continued from page 103  Based on review of clinical records and 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 one of 35 residents reviewed (Resident 25) who were receiving hospice services.  Findings include:  A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated April 22, 2025, indicated that the resident was cognitively impaired, received hospice services, and had a diagnosis of cancer.  Physician's orders and a care plan for Resident 25, dated April 15, 2025, included an order for the resident to be treated by hospice (end-of-life services) for basal cell carcinoma (skin cancer) of the left upper limb.	F 0849		

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F 0849  SS=D	Continued from page 104  As of July 1, 2025, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained updated hospice nurse aide or registered nurse charting. The last hospice nurse aide charting located on the resident's hospice chart was dated June 5, 2025, and the last registered nurse charting was dated June 3, 2025.  Interview with the Director of Nursing on July 2, 2025, at 10:10 a.m. confirmed that Resident 25's hospice nurse aide and registered nurse charting was not in the resident's clinical record and/or in the hospice provider's clinical record, and should have been.  28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0849		
F 0867  SS=D		F 0867		

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F 0867  SS=D	<p>Continued from page 105</p> <p>483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) QAPI/QAA Improvement Activities</p> <p>§483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:</p> <p>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.</p> <p>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.</p> <p>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.</p> <p>§483.75(c)(4) Facility adverse event monitoring, including</p>	F 0867	<p>New Nursing Home Administrator met with the Interdisciplinary Team Facility Directors to review the current outstanding deficiencies and the facility plan to correct these deficiencies to maintain compliance with nursing home regulations.</p> <p>Current facility residents have the ability to be affected by this alleged deficient practice.</p> <p>Quality Assurance Performance Improvement Committee Meetings will continue to be held monthly to ensure quality care is being delivered to the residents residing at the facility and cited deficiencies including recurring deficiencies are being effectively addressed and corrected.</p> <p>New Nursing Home Administrator re-educated Quality Assurance Performance Improvement Committee members on the importance of facility and interdisciplinary team collaboration to correct cited facility deficiencies</p>	<p>Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b></p>

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F 0867  SS=D	Continued from page 106  the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.  §483.75(d) Program systematic analysis and systemic action.  §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.  §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.  §483.75(e) Program activities.  §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867	and ensure plans of correction improve the delivery of care and services to residents and effectively address recurring deficiencies, including care plan timing and revisions, providing quality care, ensuring resident environments are free from accident hazards, maintaining intravenous catheters and preventing issues with the accountability of controlled medications.  New Nursing Home Administrator will hold a weekly Department Head Meeting with the Interdisciplinary Team Facility Directors to review the progress and compliance of the current plan of correction audit process. Concerns and suggestions will be provided and reviewed as needed upon review of outstanding deficiency audits to ensure that improvements are being made and the facility is moving forward and progressing in its quality care being delivered to the residents residing at the facility. Weekly Department Head Meetings will continue until	

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F 0867  SS=D	Continued from page 107  incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.  §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.  §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.  §483.75(g) Quality assessment and assurance.  §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867	facility compliance is established.  Results from audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at monthly meetings times nine months for results, areas of improvement and/or continuation of audits.	

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F 0867  SS=D	Continued from page 108  (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.  This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867  SS=D	Continued from page 109  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 maintain compliance with nursing home regulations 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 State Survey and Certification (Department of Health) surveys ending June 5, July 11, and December 26, 2024, revealed that the facility developed plans 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 July 2, 2025, identified repeated deficiencies related to care plan revisions; providing quality care; ensuring that the resident's environment was free	F 0867		

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F 0867  SS=D	Continued from page 110  from accident hazards; maintaining intravenous catheters; preventing issues with the accountability of controlled medications (drugs with the potential to be abused).  The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending June 5, 2024, 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 to ensure ongoing compliance with regulations regarding care plan revisions.  The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending June 5, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684,	F 0867		

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F 0867  SS=D	Continued from page 111  revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care.  The facility's plans of correction for deficiencies regarding ensuring that the resident environment was free of accident hazards, cited during the surveys ending on July 11, 2024 revealed that audits would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F689, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding ensuring that the environment was free of accident hazards.  The facility's plan of correction for a deficiency regarding intravenous catheters, cited during the survey ending December 26, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F694,	F 0867		

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F 0867  SS=D	Continued from page 112  revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding intravenous catheters.  The facility's plans of correction for deficiencies regarding the failure to account for controlled medications, cited during the surveys ending June 5, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications.  Refer to F657, F684, F689, F694, F755.  28 Pa. Code 201.14(a) Responsibility of Licensee.  28 Pa. Code 201.18(e)(1) Management.	F 0867		

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F 0868  SS=D		F 0868		

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F 0868  SS=D	Continued from page 114  483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee  §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.  §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.  §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	Director of Nursing reviewed the Quality Assessment and Assurance Committee Meeting minutes from the first quarter of 2025 with the facility's new Medical Director.  Current facility residents have the ability to be affected by this alleged deficient practice.  Nursing Home Administrator educated the new facility Medical Director of the requirement to attend the Quality Assessment and Assurance Committee Meetings on at least a quarterly basis and provided the date of the next upcoming scheduled Quality Assurance Committee Meeting.  Nursing Home Administrator will audit attendance of members of the Quality Assessment and Assurance Committee Meetings to ensure the Medical Director attends at least on a quarterly basis monthly times six months until resolved.  Results from audits will be reviewed	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
STATE LICENSE NUMBER: <b>09750201</b>				
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F 0868  SS=D	Continued from page 115  of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.  This REQUIREMENT is not met as evidenced by:	F 0868	by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at its regularly scheduled meetings times six for results, areas of improvement and/or continuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>396088</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>07/02/2025</b>
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F 0868  SS=D	Continued from page 116  Based on review of policies and attendance records for the facility's Quality Assurance Committee, as well as staff interviews, it was determined that the facility failed to ensure that all required members of the Quality Assurance Committee attended quarterly meetings.  Findings include:  The facility's policy for Quality Assurance and Performance Improvement, dated March 12, 2025, revealed that meetings would be held at least quarterly and would include the Nursing Home Administrator, Director of Nursing, all department heads, a community member, and the Medical Director.  Review of the attendance records for the facility's Quality Assurance Committee meetings revealed that the Medical Director did not attend any meetings that were held during the first quarter of 2025.	F 0868		

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F 0868  SS=D	Continued from page 117  Interview with the Director of Nursing on July 2, 2025, at 2:30 p.m. confirmed that the Medical Director did not attend meetings of the Quality Assurance Committee that were held during the first quarter of 2025.  28 Pa code 201.18(b)(3) Management.	F 0868		
F 0880  SS=D		F 0880		

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F 0880  SS=D	Continued from page 118  483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Resident 45 was assessed with no ill effects and/or noted concerns related to License Practical Nurse 1 failing to use proper hand washing techniques during her medication administration.  Resident 29 was assessed with no ill effects and/or noted concerns related to License Practical Nurse 1 failing to use proper hand washing techniques during her medication administration.  Resident 2 was assessed with no ill effects and/or noted concerns related to License Practical Nurse 1 failing to use proper hand washing techniques during her medication administration.  Director of Nursing immediately spoke to Licensed Practical Nurse 1 regarding proper hand sanitization during medication administration, including after glove removal, with Licensed Practical Nurse 1 verbalizing understanding and willingness to comply.	Completion Date: <b>08/12/2025</b> Status: <b>APPROVED</b> Date: <b>07/21/2025</b>

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NAME OF PROVIDER OR SUPPLIER: <b>MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>4112 SPRING HILL ROAD PORTAGE, PA 15946</b>		
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F 0880  SS=D	Continued from page 119  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.  This REQUIREMENT is not met as evidenced by:	F 0880	Current facility residents receiving medications have the ability to be affected by this alleged deficient practice.  A baseline audit was completed on residents currently receiving medications to ensure licensed nurses completed hand washing/hand hygiene during medication administration, including after glove removal.  Hand washing/hand hygiene competencies were completed with current facility licensed staff and current agency licensed staff.  Direct care staff, including agency direct care staff, were re-educated on the facility's Hand Hygiene Policy, including the importance of proper hand sanitization during medication administration and after glove removal.  Facility direct care staff, including agency direct care staff, received	

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F 0880  SS=D	Continued from page 120	F 0880	<p>training regarding appropriate practices for wearing gloves, changing gloves, hand washing and hand hygiene, including when to wear and change gloves, perform hand washing and/or hand hygiene during resident care and treatment.</p> <p>Facility licensed staff, including agency licensed staff, were re-educated on preventing the spread of infection, including hand washing/hand hygiene.</p> <p>Director of Nursing/designee will audit licensed nurses administering medications to residents weekly times four weeks then monthly times three months to ensure proper hand washing/hand hygiene utilized throughout medication administration.</p> <p>Results from audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations and/or resolution at its regularly scheduled meetings times four</p>	

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F 0880  SS=D	Continued from page 121	F 0880	months for results, areas of improvement and/or continuation of audits.	

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F 0880  SS=D	Continued from page 122  Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper hand washing techniques were used during medication administration for three of three residents observed (Residents 2, 29, 45).  Findings include:  The facility's policy regarding hand hygiene, dated March 12, 2025, indicated that all employees were to follow the hand washing procedure, which included hand sanitizing, before preparing or handling medications, and after removing gloves.  Observations during the medication pass in A hall on July 2, 2025, at 8:33 a.m. revealed that Licensed Practical Nurse 1 prepared Resident 45's medications and administered them. Without sanitizing her hands, she donned gloves and entered Resident 29's room and took the resident's blood pressure. She doffed her gloves and without hand	F 0880		

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F 0880  SS=D	Continued from page 123  sanitizing she prepared and administered Resident 29's medications. She then went to Resident 2's room and donned gloves and checked the resident's blood sugar. She doffed her gloves and without hand sanitizing she prepared the resident's medications, donned gloves and administered them. Licensed Practical Nurse 1 exited the resident's room and hand sanitized at the medication cart.  Interview with Licensed Practical Nurse 1 on July 2, 2025, at 9:35 a.m. confirmed that she should have sanitized her hands between residents while doing the medication pass and after she removed her gloves.  Interview with the Director of Nursing on July 2, 2025, at 9:53 a.m. confirmed that Licensed Practical Nurse 1 did not properly sanitize her hands during medication administration and after glove removal, and she should have.  28 Pa. Code 211.12(d)(5) Nursing Services.	F 0880		



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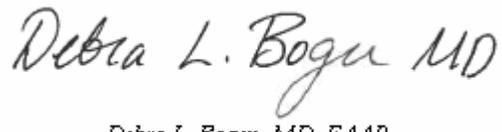
**MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC**

**STATE LICENSE NUMBER: 09750201**

**SURVEY EXIT DATE: 07/02/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY