

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2025
NAME OF PROVIDER OR SUPPLIER  Maple Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Maple Street Hazen, AR 72064	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview, record review, facility document review, and facility policy review, it was determined that facility failed to ensure residents were free from physical and psychosocial harm for 2 (Resident #5 and 23) of 3 residents reviewed for abuse.</p> <p>The findings include:</p> <p>A review of an admission Record indicted the facility admitted Resident #25 with a diagnosis of dementia with agitation and delirium.</p> <p>A review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 05/22/2025 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS also indicated the resident had exhibited physical behavioral symptoms towards others.</p> <p>A review of Resident #25 ' s Care Plan revealed it was noted on 03/03/2025 the resident had the potential to be physically aggressive.</p> <p>A review of an admission Record revealed the facility admitted Resident #5 with a diagnosis of epilepsy (a disorder where nerve cell activity in the brain is disturbed causing seizures).</p> <p>The quarterly MDS with an ARD of 04/12/25 revealed Resident #5 had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>A review of a facility incident report, dated 05/10/25 at 4:00 PM and completed by Registered Nurse (RN) #4, revealed:</p> <p>Resident #25 was removed from Resident #5 ' s room after an aide stated Resident #25 had struck Resident #5. RN #4 entered Resident #5 ' s room and observed Resident #5 holding the right side of the resident ' s face. When asked if they could explain what happened, Resident #5 stated, [Resident #25] came in here and was getting onto me and slapping me and hitting me. Resident #5 indicated Resident #25 had struck them in the stomach.</p> <p>Immediate action: Residents were separated with Resident #25 taken to the dayroom for closer observation.</p> <p>At 7:38 PM the Director of Nursing (DON) was notified of the incident between Resident #5 and #25.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>At 8:36 PM the Medical Director was notified of the incident between Resident #5 and #25.</p> <p>At 8:39 PM the Administrator was notified of the incident between Resident #5 and #25.</p> <p>A statement from Certified Nursing Assistant (CNA) #1 revealed she was in a resident room when she heard Resident #5 screaming. CNA #1 ran to Resident #5 ' s room and witnessed Resident #25 slapping Resident #5. When staff attempted removing Resident #25, Resident #25 hit Resident #5 on their right arm.</p> <p>A statement from CNA #2 revealed they were in another resident room when yelling was heard. CNA #2 went into Resident #5 ' s room and witnessed Resident #25 hitting Resident #5 and taking linens off Resident #5 ' s bed. CNA #2 moved Resident #25 to the dayroom and told the nurse.</p> <p>A stop sign was placed at Resident #5 ' s door to prevent other residents from entering the room. Facility training was completed with staff regarding abuse, neglect, and dementia.</p> <p>During an interview on 06/02/25 at 11:37 AM, Resident #5 stated, [Resident #25] came in and hit my arm and made a big bruise. I don't know why [Resident #25] came in, [Resident #25] just walked in here.</p> <p>During an interview on 06/04/2025 at 12:52 PM, Resident #5 revealed that they were going into their room and getting out of their wheelchair. Resident #5 stated, [Resident #25] walked in and hit my arm and left a big bruise on my arm. I pushed my call light, and the nurse came and got them. Resident #5 reported feeling scared and pain when they were being hit. Resident #5 verbalized telling the Social Director about the bruise.</p> <p>During an interview on 06/04/2025 at 10:53 AM, CNA #1 verified that she witnessed Resident #25 slapping Resident #5 two or three times, and punching them on the arm one time. Resident #25 was trying to take the linens off Resident #5 ' s bed and Resident #5 was stating, No, no, no. CNA #1 confirmed that they put a stop sign across Resident #5 ' s door so Resident #25 couldn't come in and sat Resident #25 alone and kept them away from everybody. CNA #1 confirmed Resident #5 had a bruise on their right arm and their face was red after the incident. CNA #1 said they reported the incident immediately.</p> <p>During an interview on 06/04/25 at 1:42 PM, CNA #1 verbalized that the bruise to Resident #5 ' s right arm was from the same day of the incident on 05/10/2025.</p> <p>During an interview on 06/04/2025 at 5:07 PM, CNA #1 verbalized that depending upon the day, somedays Resident #25 wandered, slept, or was angry. Resident #25 also hit and yelled out. When Resident #25 has behaviors, we leave them alone and let them calm down, the behaviors don't last long.</p> <p>During an interview on 06/03/25 at 1:31 PM, License Practical Nurse (LPN) #3 verbalized that a stop sign had been placed on Resident #5 ' s door to ensure safety.</p> <p>During an interview on 06/04/2025 at 12:20 PM, LPN #3 revealed Resident #5 had a bruise from an incident on 05/10/2025. LPN #3 stated, There was a whole reportable, I thought, I informed the MDS Coordinator and the DON regarding the bruise.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/04/2025 at 5:09 PM, LPN #3 verbalized that with perineal care and personal care Resident #25 often became agitated, and stated the resident did wander.</p> <p>During an interview on 06/04/25 at 6:53 PM, RN #4 stated, [Resident #25] went into [Resident #5 's] room. [Resident #5] was saying that they got hit in the stomach or arm, but I can't remember. RN #4 stated, I want to say they put the stop sign on the door that Monday. RN #4 stated, We would just watch [Resident #25] as close as we can. [Resident #25] can become aggressive, labile, and hard to predict. Resident #25 is aggressive. They doesn't like any kind of self-care and tend to get violent with the staff and has behaviors all the time.</p> <p>During an interview on 06/03/25 at 8:13 AM, the DON verbalized that a report for Resident #25 striking Resident #5 was completed, and immediate separation between the two residents was done. Resident #25 was placed on one-on-one supervision, and a stop sign was place on Resident #5 ' s door. Resident #5 was educated to immediately come out and get a staff member if someone came into their room.</p> <p>During an interview on 06/04/2025 at 9:50 AM, the DON verbalized a reportable was not done due to there being no injuries.</p> <p>During an interview on 06/04/2025 at 11:03 AM, the Administrator verified a CNA witnessed Resident #25 slapping Resident #5 ' s cheek. She confirmed that a stop sign was placed the next day.</p> <p>A review of an admission Record indicated the facility admitted Resident #23 with Alzheimer's disease (progressive disease that destroys memory and other important mental functions).</p> <p>The admission MDS with an ARD of 04/16/2025, revealed resident #23 had a BIMS score of 06, which indicated the resident had severe cognitive impairment.</p> <p>A review of a facility reportable, dated 05/27/25 at 6:40 AM and completed by RN #4, revealed:</p> <p>CNA #5 was in another room when they heard someone screaming. CNA #5 observed Resident #25 striking Resident #23 with a cane. CNA #5 attempted to stop Resident #25, but Resident #25 attempted to hit CNA #5 with the cane. CNA #5 was able to get Resident #25 to put the cane down and then called for assistance from CNA #6. Both CNA #5 and #6 were unsuccessful in removing Resident #25 from the room. RN #4 was contacted by CNA #6. When RN #4 entered the room, Resident #25 became aggressive towards RN #4 while the RN was removing Resident #25 from the room.</p> <p>Resident #23 verbalized to RN #4, [Resident #25] came in here, took my cane from me, and began hitting me with it over and over. RN #4 assessed Resident #23 and found discoloration to the right lower extremity in the shin area.</p> <p>A witness statement from CNA #5 revealed she heard someone screaming. CNA #5 reported Resident #25 was in Resident #23 ' s room hitting them with their cane. CNA #5 came in and tried to stop them. CNA #5 revealed, [Resident #25] was trying to hit me. CNA #5 got Resident #25 to put the cane down and then got CNA #6, who went and got RN #4.</p> <p>A witness statement from CNA #6 revealed Resident #25 hit Resident #23 on the legs with the cane. CNA #6 then went to get RN #4 to assist in removing Resident #25 from the room.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A witness statement from RN #4 revealed Resident #25 took Resident #23 ' s cane and began hitting Resident #23 with it. RN #4 removed Resident #25 from the room.</p> <p>A witness statement from Resident #23 indicated the resident stated, I was lying in bed and heard my bedroom door open and noticed that it was [Resident #25]. I grabbed my cane that was on my bedside drawer by my bed and pointed it at them and told them to get out. They kept walking towards me and grabbed my cane and hit me several times over my legs with my cane.</p> <p>During an interview and observation on 06/05/2025 at 10:50 AM, Resident #23 was seen with three bruises that were yellowish in color to their right knee. Resident #23 reported Resident #25 beat them with a cane, striking them 5 or 6 times. Resident #23 reported being shocked by the attack, stating, I wasn't thinking about getting hit in a place like this. It irritated me that they had people walking around doing that. Resident #23 reported that no staff were around when it happened. I'm cautious when I walk out the room. I don't feel free to just stroll down the hall anymore. I don't know why they choose me to attack. I don't know if I looked vulnerable or what. I'm not sure what their thought process was.</p> <p>A review of Resident #23 ' s skin observation, dated 05/27/2025 at 8:15 AM, revealing bruising to right lower front leg.</p> <p>A review of Resident #23 ' s skin observation, dated 05/28/2025 at 8:33 AM, revealed bruising to right lower front and rear leg and front of right knee.</p> <p>During an interview on 06/05/2025 at 11:34 AM, CNA #6 revealed that Resident #23 seemed to be nervous following the incident. CNA #6 reported doing a facility training on the incident after it happened.</p> <p>During an interview on 6/05/2025 at 11:47 AM, RN #4 revealed Resident #25 was sent out as an immediate intervention to ensure safety for residents affected and other residents on the unit. RN #4 reported Resident #25 was a one-on-one supervision for a couple of days. RN #4 reported Resident #23 had a bruise on the side of their right leg following the incident.</p> <p>During an interview on 06/05/25 at 11:38 AM, the DON verified that Resident #23 reported another resident struck them, took their cane from them, and began hitting them over and over.</p> <p>During an interview on 06/05/25 at 11:55 AM, the Administrator reported the incident between Resident #25 and Resident #23 seemed to be an isolated incident. The Administrator reported to be working on allowing that hall to have its own nurse. She confirmed that it was important to ensure proper interventions were in place for all residents that have potential for harm to insure all residents' safety.</p> <p>Review of an undated policy titled, Abuse policy, indicated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown sources (abuse) shall be immediately reported to the administrator/designee and the Director of Nursing and promptly reported to local, state, and federal agencies (as defined by current regulations). These allegations will be thoroughly investigated by the facility management and the findings for abuse investigations will be reported as per local, state, and federal regulations.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview, record review, and facility policy review, it was determined that the facility failed to report a resident-to-resident altercation to the Office of Long-Term Care for two (Resident #5 and Resident #25) of two residents reviewed for abuse.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. A review of Resident #5 ' s admission Record indicted the facility admitted the resident with diagnoses of intellectual disabilities and history of traumatic brain injury, which included epilepsy. <ol style="list-style-type: none"> <li>a. A review of Resident #5 ' s quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/12/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact mental cognition.</li> <li>b. A review of Resident #5 ' s, Care Plan, initiated 12/18/2022, indicated the resident was deemed appropriate for placement on the memory care unit. The Care Plan also revealed interventions, with an initiation date of 02/18/2025, which directed staff to redirect the resident when exit seeking or if there was an altercation with another resident, speak directly with resident in a calm manner with short sentences and simple questions, attempt task again in a calm manner, when or if the resident becomes agitated or combative.</li> </ol> </li> <li>2. A review of Resident #25 ' s admission Record indicted the facility admitted the resident, with diagnoses which included moderate vascular dementia. <ol style="list-style-type: none"> <li>a. A review of Resident #25 ' s quarterly MDS with an ARD of 05/22/2025, revealed the resident had a BIMS score of 03, which indicated severe cognitive impairment.</li> <li>b. A review of Resident #25 ' s, Care Plan, revised 03/03/2025, revealed the resident had the potential to be physically aggressive. The Care Plan also revealed interventions, with initiation dates of 03/03/2025 and 03/26/2025, that directed staff to redirect resident, intervene before agitation escalates, redirect from source of distress, utilize calm conversations with resident. If resident is aggressive, walk away and attempt later.</li> </ol> </li> <li>3. During an interview on 06/02/2025 at 11:37 AM, Resident #5 stated, [Resident #25] came in (into Resident #5 ' room) and hit my arm and made a big bruise. I don't know why .they just walked in here.</li> <li>4. During an interview on 06/04/2025 at 9:50 AM, the Director of Nursing (DON) revealed that there was not a reportable done with Resident #5 and Resident #25 due to no injuries. She verbalized her last training, regarding abuse was a week ago.</li> <li>5. During an interview on 06/04/2025 at 10:53 AM, Certified Nursing Assistant (CNA) #1 stated, I witness them [Resident #25] slapping [Resident #5] two or three times and punched them on the arm one time. [Resident #25] were trying to take covers off [Resident #5 ' s] bed and [Resident #5] was saying, No, no, no. CNA #1 verbalized they had informed administration immediately following the incident.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. During an interview on 06/04/2025 at 12:20 PM, Licensed Practical Nurse (LPN) #3 revealed Resident #5 had a bruise from an incident on 05/10/2025. LPN #3 stated, There was a whole reportable, I thought, and I informed the MDS Coordinator and DON regarding the bruise.</p> <p>7. During an interview on 06/04/2025 at 12:52 PM, Resident #5 reported feeling scared during the time of the incident, and pain when struck. Resident #5 revealed they had a bruise from the hit and had informed the Social Director of the incident.</p> <p>8. During an interview on 06/04/2025 at 1:42 PM, CNA #1 confirmed the bruise to Resident #5 's right arm was from the same day of the incident, on 05/10/2025.</p> <p>9. During an interview on 06/05/25 at 4:11 PM, the Medical Director revealed that he was not notified of the incident that happened on 05/10/2025. He verbalized that there was an on call that could have been notified.</p> <p>10. A review of a facility Incident Report, dated 05/10/2025, indicated Resident #5 was gotten onto and hit and slapped by Resident #25. The incident report revealed the DON was notified of the incident on 05/10/2025 at 7:38 PM, and the Administrator was notified of the incident on 05/10/2025 at 8:39 PM.</p> <p>11. A review of a facility, Abuse and Neglect and Dementia training, dated 05/27/2025, acknowledged with staff listed above stating Investigate and report any allegations of abuse within timeframes as required by federal requirements.</p> <p>12. A review of an undated facility policy titled, Abuse Policy, indicated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown sources (abuse) shall be immediately reported to the Administrator/Designee and the Director of Nursing [DON] and promptly reported to local, state, and federal agencies (as defined by current regulations).</p>		