

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Maplewood Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 125 W Schoolhouse Lane Philadelphia, PA 19144	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policy, review of facility documentation, review of clinical records, and interviews with residents and staff, it was determined that the facility failed to ensure that the resident environment remained free of accident hazards by failing to monitor the temperature of hot water beverages served to a resident. This failure resulted in actual harm to Resident R1 who spilled a hot water beverage and sustained an abdominal and chest burn injury, for one of five residents reviewed. (Resident R1)</p> <p>Findings include:</p> <p>Review of facility policy on Hot Liquid with a most recent revision date of January 17, 2019, revealed that under section Policy: Residents will be served coffee, hot water, soup, or any hot liquid at a palatable temperature that will not burn the skin. Under section Purpose: To ensure residents are served coffee, hot water, soup, or any liquid that will not burn the skin if spilled on a resident. Under section Guidelines: #1. Coffee will be brewed at recommended and soup will be cooked to appropriate temperature. #2 Coffee, hot water, soup or any hot liquid is to leave kitchen at a range of 140 to 168 . #3 Coffee, hot water, soup, or any hot liquid temperature at point of service should be at or below 145 . #4. If coffee, hot water, soup, or any hot beverage is served to resident at a different time other than at meals, temperature should be taken before service and not served above 145 F.</p> <p>Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses of CVA (cerebrovascular accident) with right sided weakness, Bipolar disorder, and COPD (chronic obstructive pulmonary disease)</p> <p>Review of Resident R1's quarterly Minimum Data Set (MDS- assessment of resident needs) dated May 29, 2024, revealed a BIMS (brief interview for mental status) score of 15 suggesting that Resident R1 was cognitively intact.</p> <p>Review of Resident R1's care plans revealed that the resident was care planned for impairment related to safety awareness, reduced independence with activities of daily living, and difficulty navigating the SNF (skilled nursing facility) environment. Resident R1 has impaired cognitive function/dementia or impaired thought processes related to Dementia.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of the resident's care plan revealed a care plan developed on August 11, 2024 related to a 2nd degree burn to resident's right upper quadrant and right breast. Interventions included to keep area clean and dry, assistance with handling all meals trays and treatments done as ordered.</p> <p>Review of Resident R1's nursing note dated July 29, 2024, time stamped 2:58 p.m. revealed that Resident R1 was brought to the 3rd floor and stated she spilled hot water on herself in the main dining room. RUQ (right upper quadrant) abdomen and R (right) breast noted with redness. Resident stated she was holding tray and spilled hot water on herself. A&D applied to area; pain medication offered resident denied. MD (physician) notified, to monitor area q (every) shift.</p> <p>Review of Resident R1's wound progress notes dated August 8, 2024, revealed that Resident R1 was seen by wound care for an assessment and treatment recommendation for a burn secondary to hot water on right breast, RLQ (right lower quadrant)/RUQ (right upper quadrant) ABD (abdominal). Wounds present < 1 week. Patient initially had pain, now improved. No s/s (sign/symptom) of infection. Right breast burn: 1.8 x 0.8 x 0.05 centimeters, right abdominal burn: 8 x 8 x 0 centimeters.</p> <p>Interview with Resident R1 conducted on August 14, 2024, at 12:07 p.m revealed that she forgot the date of the incident but on the day of the incident, she requested to have lunch in the main dining room on the first floor. Resident R1 revealed that she asked Dietary aide, Employee E4 to bring her lunch to the dining room. Resident R1 further revealed that she was in the lobby area in front of the front desk waiting for Employee E4 to bring her lunch. When employee E4 brought her lunch in a tray.</p> <p>Resident R1 alleged that she asked Dietary aide, Employee E4 to bring the tray to the dining room but Dietary aide, Employee E4 refused to bring the tray to the dining room stating that she didn't have time to do it. The resident then carried the tray herself while propelling herself with her feet on the wheelchair. Further, Resident R1 also alleged that she asked Dietary aide, Employee E4 to take the hot water out of the tray but Dietary aide, Employee E4 left it on the tray. Resident R1 then carried tray and spilled the cup of hot water on herself on her way to the dining room which caused her to get burned on her chest.</p> <p>Interview with Dietary aide, Employee E4 conducted on August 14, 2024, at 1:13 p.m. revealed that when preparing the food trays that go to the unit, she puts the food together according to the menu. Coffee and hot water is poured, then it goes in the truck, goes upstairs then nurse aides served the tray. Further Dietary aide, Employee E4 revealed that she was never assigned to check the temperature.</p> <p>Continued interview with Dietary aide, Employee E4 revealed that Resident R1 normally eats in Main Dining Room on the first floor but that day she wanted to eat upstairs. However, Resident R1 changed her mind and decided to eat in the main dining room. Lunch service was already finished at the time, so Resident R1 requested for a special lunch tray. Employee E4 also revealed that she had to prepare a special tray for Resident R1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further interview with Dietary aide, Employee E4 confirmed that she did not check the temperature of the food that she prepared for Resident R1. Employee E4 revealed that when she took Resident R1's tray out of the kitchen, resident was in the lobby at the front desk and that she handed the tray to Resident R1, the resident took the tray from her hand. Dietary aide, Employee E4 revealed that the front desk Receptionist, Employee E8 and Social Worker, Employee E6 were near the front desk. Social Worker, Employee E6 offered to take the tray from Resident R1 and offered to carry it to the dining room but Resident R1 refused. Social Worker, Employee E6 attempted to take the tray from Resident R1 but resident refused. Employee E4 further revealed that when she left Resident R1 was still in front of the front desk and that she was not aware the resident had burned herself until later.</p> <p>Interview with Director of Dietary, Employee E3 conducted on August 14, 2024, at 1:26 p.m. confirmed that Dietary aide, Employee E4 did not check the water temperature before taking the tray to Resident R1. Employee E3 stated that the cooks conduct a random food temperature check during tray line and performs a random check the coffee and water temperatures upon poring and then 15 minutes later.</p> <p>Interview with Social Worker, Employee E6 conducted on August 14, 2024, at 1:37 pm revealed that she was in the lobby at the time of the incident. Social Worker, Employee E6 revealed that she saw Dietary Aide, Employee E4 coming out from the kitchen area and Resident R1 was sitting at the front desk. Employee E6 revealed that she saw Dietary aide, Employee E4 handed Resident R1 a lunch tray. Employee E6 also revealed that she asked Resident R1 if she can carry the tray for her and that Dietary aide, Employee E4 then also offered to take tray for Resident R1, but Resident R1 insisted that she can do it. Employee E6 revealed that she left after and did not see the incident and did not know where it happened. She found out about it later.</p> <p>Interview with front desk Receptionist, Employee E8 conducted on August 14, 2024, at 12:18 p.m. revealed that he was manning the front desk at the time of the incident. Receptionist, Employee E8 revealed that he saw Dietary aide, Employee E4 give Resident R1 something but didn't know what it was and that he was busy doing something else at the time.</p> <p>Interview with Recreation aide, Employee E7 conducted on August 14, 2024, at 1:44 p.m. revealed that on July 29, 2024 she was going through dining room and saw Resident R1 outside the dining room in the lobby area and she had a tray on lap and the tray had food on it, asked if she needed help and she refused. Stated I got it. Recreation aide, Employee E7 then proceeded to go into the dining room and left Resident R1 outside the dining room area.</p> <p>Review of cooling/heating log for July 28, 2024, to August 10, 2024, revealed that coffee temperature was checked every day for starting temp and 15 minutes after every day for breakfast, lunch, and dinner</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of security camera located in the lobby area revealed that the camera orientation was facing the entrance of the lobby and shows one of the doorways leading to the kitchen. Further review of the lobby security camera revealed that at 1:56 p.m. resident was seen wheeling herself to the front desk and stayed in front of the front desk. At 1:58 p.m Dietary aide, Employee E4 was seen walking out of the kitchen door with a tray in her hands. Dietary aide, Employee E4 approached the front desk and handed the tray to resident. Social Worker, Employee E6 was seen approaching Resident R1 and what appears to be a verbal interaction between Resident R1 and Social Worker, Employee E6 occurred. Dietary aide, Employee E4 and Social Worker, Employee E6 was then seen walking away from the Resident R1 and Resident R1 wheeled herself towards the direction of the entrance to the dining room door. There was no video coverage for area leading towards the dining room.</p> <p>The facility failed to test the temperature of a hot water beverage prior to providing it to Resident R1. This failure resulted in actual harm to Resident R1 who spilled the hot water beverage and sustained a second degree abdominal and chest burn.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.6(c)(d) Dietary Services</p>		