

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 08/28/2025
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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>Based on staff and resident interviews and review of clinical records, it was determined that the facility failed to ensure that documented room change notifications to the resident and/or emergency contact were provided for one out of 33 residents reviewed (Resident R133). Findings include: During an interview with Resident R133 on August 27, 2025, at 2:07 p.m. stated facility moved his room without providing prior notice. The resident stated the staff came into his room and asked him to move. The resident stated he was not prepared and did not pack his belongings, and staff did not give him the opportunity to do it himself because it was important for him to pack his belongings himself. Review of room change notification for Resident R133 dated February 19, 2025, revealed that resident had room change on February 19, 2025, and the date of notification was on February 19, 2025. The question for written copy provided to was answered N/A (Not Applicable Resident is alert and oriented X3. Further review of clinical records revealed no evidence that the facility provided written notice to the resident prior to the room change. Interview with Administrator on August 28, 2028 at 11:00 a.m. confirmed that the facility did not provide written notice to Resident R133 when his room was changed on February 19, 2025. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(c.3) (1) Resident rights</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Based on review of facility policies and clinical records and staff interviews, it was determined that the facility failed to ensure that a written summary of the baseline care plan was provided to the resident and/or the resident's representative for one of two residents reviewed (Resident R151). Findings include: Interview Resident R151 on August 26, 2025, at 11:00 a.m. stated he was not provided a copy of the baseline care plan or medication list since his admission. A review of Resident R151's clinical record reviewed that the resident was July 28, 2025. Review of the clinical record for Resident R151 revealed no evidence that the facility provided a written summary of baseline care plan and a medication list to the resident or the resident representative. Interview with the Social Service Director, Employee E8 on August 28, 2025, at 9:54 a.m. confirmed that the facility did not provide a written copy of baseline care plan to Resident R151 or his representative. Employee E9 also stated that the facility did not have a process of providing a copy of the baseline care plan or medication list 28 Pa Code 211.10(a) Resident care policies.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to update resident's physician orders related to dialysis schedule for one of one resident review receiving hemodialysis treatment (Resident R8). Findings Include: Review of the medical record revealed that Resident R8 was admitted on [DATE], with diagnosis including, but not limited to end stage renal disease (the final stage of chronic kidney disease, where kidneys can no longer function adequately, requiring dialysis or a kidney transplant for survival). Further review of the clinical record for Resident R8 revealed a July 25, 2025, physician's order for hemo dialysis at a local dialysis center with a 10:00 a.m. chair time every Monday, Wednesday and Friday. Interview with the Unit Clerk, Employee E7 on the second floor on August 28, 2025, at 9:30 a.m. revealed that Resident R8 was not on the floor and was at dialysis. When asked why he was at dialysis on a Thursday when his order was for Monday, Wednesday and Friday, she indicated that Resident R8 has been going four days a week for the past few weeks. When asked about the physician's order she got the Unit Manager, Employee E4, who confirmed that the order needed to be updated to include four days a week adding Thursdays to the order. A review of Resident R8's nursing progress notes revealed that the resident was at dialysis on Thursday August 14, 2025, and Thursday August 21, 2025. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c) Nursing services</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of four residents sampled for post-traumatic stress disorder(PTSD) care for one of 33 residents reviewed. (Resident R4). Findings include: A review of the clinical record revealed that Resident R4 was admitted to the facility, with diagnoses to include traumatic subdural hemorrhage(a collection of blood that accumulates between the inner layer of the skull (dura mater) and the surface of the brain after a head injury), major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy levels that can significantly impact daily life and post-traumatic stress disorder (PTSD) (a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal loss). A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for Resident R4 dated May 23, 2025, Section I, Active Diagnoses, Psychiatric/Mood Disorder, question I6100, indicated the resident has post-traumatic stress disorder (PTSD). Resident R4's current care plan, dated June 17, 2025, revealed a care plan for history of traumatic event. Further review of the care plan did not address possible triggers that may cause re-traumatization. Interview with the Social Service Director, Employee E9, on August 28, 2025, at 9:54 a.m confirmed that Resident R4's care plan for PTSD did not include resident's possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that the facility failed to offer and/or provide the influenza and pneumococcal immunization for three of five residents reviewed (Resident R43, R55 and R151).The findings include:Review of the clinical record for Resident R43 revealed the resident was admitted to the facility on [DATE]. The resident was [AGE] years old.Review of R43's immunization records revealed no evidence that the resident received the influenza vaccine, or the facility offered the influenza vaccine. Review of the clinical record for Resident R55 revealed the resident was admitted to the facility on [DATE]. The resident was [AGE] years old.Review of R55's immunization records revealed no evidence that the resident received the influenza vaccine, or the facility offered the influenza vaccine.Review of the clinical record for Resident R151 revealed the resident was admitted to the facility on July28, 2025. The resident was [AGE] years old.Review of R151's immunization records revealed no evidence that the resident received the pneumococcal vaccine, or the facility offered the pneumococcal vaccine.28 Pa Code: 201.14 (a) Responsibility of licensee28 Pa Code: 201.12 (d)(1) Nursing services</p>		