

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024
NAME OF PROVIDER OR SUPPLIER: MAPLEWOOD NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 WEST SCHOOLHOUSE LANE PHILADELPHIA, PA 19144		
STATE LICENSE NUMBER: 033002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0684 SS=D	Based on an Abbreviated Survey in response to two complaints, completed on December 11, 2024 it was determined that Maplewood Nursing and Rehab Center 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 related to the health portion of the survey process	F 0684		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024	
NAME OF PROVIDER OR SUPPLIER: MAPLEWOOD NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 033002		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 WEST SCHOOLHOUSE LANE PHILADELPHIA, PA 19144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 1 483.25 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	Immediate corrective action: Placed a call to POA regarding care conference and follow up on resident's procedure. Discussed that medical records were able to retrieve additional information and will ask for a new script to get the scan necessary for Hershey medical. On 12.12. Authorization for release of information was Sign and fax to Hershey medical Department of Neurosurgery for medical record release of information for insurance purposes. Appointment and scan approved by insurance. Stealth scan to take place on January 10th @10am. Family aware. House wide corrective action: Auditing all current residents to ensure follow up appointments/testing has been completed as requested. NHA or designee will complete weekly audits x4 to ensure timely appointments and follow-up if applicable. QA meeting will	Completion Date: 01/05/2025 Status: APPROVED Date: 12/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: MAPLEWOOD NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 033002	STREET ADDRESS, CITY, STATE, ZIP CODE: 125 WEST SCHOOLHOUSE LANE PHILADELPHIA, PA 19144
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 2	F 0684	determine the need for continued monthly auditing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024
NAME OF PROVIDER OR SUPPLIER: MAPLEWOOD NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 WEST SCHOOLHOUSE LANE PHILADELPHIA, PA 19144		
STATE LICENSE NUMBER: 033002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 3 Based on review of facility provided documentation, interview with staff and review of clinical record, it was determined that facility failed to ensure that require information to obtain an imaging study was submitted for one out of nine residents reviewed. (Resident R4) Findings include: Review of Resident R4's clinical record that the resident was admitted to facility on January 27, 2023 with medical history of left basal ganglia, intraparenchymal hemorrhage (bleeding within brain parenchyma), status post craniectomy, stroke affecting right dominant side, cognitive communication deficit, encounter for surgical aftercare following surgery on the nervous system, depression, aphasia (difficulty speaking), dysphagia (difficulty swallowing),and gastrostomy status. Review of facility provided documentation revealed Resident R4 had left decompressive	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024	
NAME OF PROVIDER OR SUPPLIER: MAPLEWOOD NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 033002		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 WEST SCHOOLHOUSE LANE PHILADELPHIA, PA 19144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 4 hemicraniectomy (neurosurgical procedure that removes part of the brain) completed prior to admission to facility, on January 2, 2023. On April 16, 2024, Resident R4 had consult regarding neurosurgery with recommendation for "stealth CT ordered for prosthetic manufacturing." Further review of Resident R4's clinical record revealed that on May 7, 2024, nurse aide Employee E3, contacted Resident R4's insurance company regarding "stealth CT scan," - "many times to see if the scan had gotten approved. There is no accurate information at the moment because they never received the information as requested. I will re-fax the information to the insurance company." Further review of Resident R4's clinical record revealed that on May 24, 2024, nurse aide - Employee E3, contacted Resident R4's insurance company regarding "CT scan of abdomen/pelvis with and without contrast," for which "insurance	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024	
NAME OF PROVIDER OR SUPPLIER: MAPLEWOOD NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 033002		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 WEST SCHOOLHOUSE LANE PHILADELPHIA, PA 19144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	<p>Continued from page 5</p> <p>company denied service and will not approve due to lack of medical information."</p> <p>Reviewed facility provided note from department of neurosurgery, dated April 26, 2024, which indicates that "[Resident R4] requires a stealth CT scan to have a PEEK customized implant manufactured for his reconstructive cranioplasty.."</p> <p>Per phone interview with Resident R1's insurance company representatives on Wednesday, December 11, 2024 at 11:22 AM, and again at 11:35 AM, revealed that Resident R4 does not have any medical information submitted on his behalf in order to be approved for stealth CT scan and CT scan for abdomen/pelvis. Further interview with representatives revealed that insurance company requires Resident R4's prior imaging tests that show a need for further imaging, any current or completed treatment for the problem, and any lab work up, scope study, or physical exams.</p> <p>Facility was unable to provide evidence that</p>	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395865	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024	
NAME OF PROVIDER OR SUPPLIER: MAPLEWOOD NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 033002		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 WEST SCHOOLHOUSE LANE PHILADELPHIA, PA 19144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 6 required medical information was submitted to Resident R4's insurance company. Interview on December 11, 2024 with the facility's Administrator and Assistant of Director of Nursing confirmed the findings. 28 Pa. Code 211.12(d)(1) Nursing services	F 0684		



Certified End Page

MAPLEWOOD NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 033002

SURVEY EXIT DATE: 12/11/2024

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