Department of Human Services
Bureau of Human Service Licensing

June 1, 2021

[redacted] ADMINISTRATOR
MARIS GROVE INC
500 MARIS GROVE WAY
GLEN MILLS, PA 19342

RE: MARIS GROVE
500 MARIS GROVE WAY
1ST AND 3RD FLOORS
GLEN MILLS, PA, 19342
LICENSE/COC#: 13466

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/22/2021, 04/23/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Mia Johnson

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *MARIS GROVE* **License #**: *13466* **License Expiration Date**: *03/11/2022*
Address: *500 MARIS GROVE WAY, 1ST AND 3RD FLOORS, GLEN MILLS, PA 19342*
County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *6103874630* **Email**: [redacted]

Legal Entity

Name: *MARIS GROVE INC*
Address: *500 MARIS GROVE WAY, GLEN MILLS, PA, 19342*
Phone: *6103874630* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/31/2009* **Issued By**: *Concord Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *118* **Waking Staff**: *89*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *04/23/2021*

Inspection Dates and Department Representative

04/22/2021 - On-Site: [redacted]
04/23/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *61*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Monarch Way* **Capacity**: *22* **Residents Served**: *21*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *61*
Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *57* **Have Physical Disability**: *0*

Inspections / Reviews

04/22/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *05/17/2021*

5/20/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/01/2021*

6/1/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 01/02/20, the home discovered a medication error for resident #1. The home did not report this medication error to the Department until 01/06/20.

On 02/19/20, the home discovered that resident #2 missed three days of Simvastatin. The home did not report this medication error to the Department until 02/21/20.

On 03/26/20, a medication error was discovered for resident #3. The home did not report this medication error to the Department until 03/28/20.

On 01/06/21, a medication error was discovered for residents #4, #5 and #6. The home did not report this medication error to the Department until 01/29/21.

On 01/23/21, there was a incident of resident to resident abuse between resident #7 and #8. The home did not report this incident to the Department until 01/25/21.

On 01/27/21, staff witnessed an altercation in which resident #7 grabbed and pulled the arm of resident #9. The home did not report this resident to resident altercation to the Department until 01/29/21.

On 01/27/21, resident #7 was pushing resident #10 in [redacted] wheelchair against [redacted] will. Then resident #11 walked up to resident #7 and pulled [redacted] by the hair and necklace. The home did not report this resident to resident altercation to the Department until 01/29/21.

On 03/21/21, resident #12 sustained an unwitnessed fall. The home did not report this fall incident to the Department until 03/25/21.

16c - Written Incident Report *(continued)*

Plan of Correction **Accept**

#1A

Deficiency: 2600.16c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in 2600.15 (relating to abuse reporting covered by law). *Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Staff processing reportable incidents have been re-educated on 2600.16c requirements.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

PC Manager or Designee will monitor reportable incidents quarterly to ensure that all reportables are submitted within the required timeframe.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

PC Administrator or designee will maintain ongoing monitoring/auditing of reportable incident procedures to ensure ongoing compliance.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored through our facility Quality Assurance/Performance Improvement program. In-servicing to be completed by May 31, 2021.

Completion Date: *05/31/2021*

Document Submission **Implemented**

Education and acknowledgement of regulation signed off by all staff who submit reportable incidents and conditions completed on 5/21/2021.

28e - Death of a Resident

1. **Requirements**

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

28e - Death of a Resident *(continued)*

Description of Violation

Resident #13 passed away on [redacted]. Resident #13's personal belongings were removed from the room on [redacted]; however, the refund check was dated [redacted].
Resident #14 passed away on [redacted]. Resident #14's personal belongings were removed from the room on [redacted]; however, the refund check was dated [redacted]
Resident #15 passed away on [redacted]. Resident #15's personal belongings were removed from the room on [redacted]; however, the refund check was dated [redacted]
Resident #16 passed away on [redacted]. Resident #16's personal belongings were removed from the room on [redacted]; however, the refund check was dated [redacted].
Resident #17 passed away on [redacted]. Resident #17's personal belongings were removed from the room on [redacted] however, the refund check was dated [redacted].
Resident #18 passed away on [redacted]. Resident #18's personal belongings were removed from the room on [redacted] however, the refund check was dated [redacted].
Resident #19 passed away on [redacted]. Resident #19's personal belongings were removed from the room on [redacted] however, the refund check was dated [redacted].

28e - Death of a Resident *(continued)*

Plan of Correction **Accept**

#2B

Deficiency: 2600.28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act. The home shall keep documentation of the refund in the resident's record. *Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Maris Grove business office team was educated on this regulation. Business office team is currently working with the Erickson corporate office to identify ways to meet this regulation in an ongoing manner.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Maris Grove business office will run a discharge report monthly to identify residents owed a refund. The team will ensure that refunds are processed within the required timeframe.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Business office will create a spreadsheet to track refunds to ensure refunds are issues within the required 30 day window.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Refund procedures will be audited, tracked, and reported on as part of our quarterly Quality Assurance program. Goal is to achieve 100% compliance by the end of 3rd quarter, Sept 2021. Personal Care Manager or designee will continue to work with business office to ensure with ongoing compliance.

Completion Date: *09/30/2021*

Document Submission **Implemented**

Education completed and signed off by business office representatives and PC Manager. Please see attached documentation.

85a - Sanitary Conditions

1. **Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

85a - Sanitary Conditions *(continued)*

Description of Violation

On 04/23/21, the bathroom curtains in bedrooms [redacted] and [redacted] had a brown stain on them.

Plan of Correction **Accept**

#3C

Deficiency: 2600.85.a. Sanitary conditions shall be maintained.

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Housekeeping department immediately addressed curtains identified during the annual state inspection. The two residents affected by the deficiency were notified of the concern and agreeable to having their curtains temporarily removed for cleaning.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

On 04/23/21 housekeeping team completed a sweep of resident rooms in both Personal Care and Memory Care in order to address any additional stains or discolorations in resident bedrooms. Housekeeping to include bathroom curtain checks as part of their regular daily housekeeping rounds. A plan is being developed to create a standardized plan for checking and laundering resident bathroom curtains.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

PC Administrator or designee will complete regular environmental rounds with housekeeping and maintenance departments in order to monitor resident living spaces for compliance. Rehab team will be notified of audit findings n those residents utilizing curtains instead of doors. Each resident room will be reviewed for appropriateness of therapy's intervention to remove bathroom door in favor of a curtain. Audit findings will be reported on during quarterly Quality Assurance meetings.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Audit findings will be included and reported on in facility Quality Assurance meetings for the next quarter. Goal is to obtain/maintain 100% compliance by Q3, September 2021.

Completion Date: *04/23/2021*

Document Submission **Implemented**

Housekeeping completed a sweep of resident rooms in Personal Care and Memory Care for bathroom curtain stains or discolorations on 4/23/2021. Any concerns were immediately addressed by Housekeeping Department. Plan is ensure that curtain checks are part of the daily room cleaning schedule.

85e - Trash Outside Home

1. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

There was a broken wood pallet outside the trash containers.

Plan of Correction **Accept**

#4D

Deficiency: 2600.85.e. Trash outside of the home shall be kept in covered receptacles that prevent the penetration of insects and rodents. *Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Housekeeping department was educated on this regulation and the presence of a broken pallet in loading dock area. Housekeeping supervisor posted signage in the loading dock area to reinforce appropriate trash disposal procedures. Loading dock area is to be checked for trash and cleaned daily. Additionally, loading dock area will be checked following deliveries to ensure vendors are also complying with trash disposal procedures.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Housekeeping supervisor or designee will continue to check loading dock area to ensure appropriate trash disposal procedures are followed.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Daily and weekly environmental checks to continue. PC Administrator or designee will complete randomized monthly audits to ensure ongoing compliance with this regulation.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Audit findings will be included and reported on in facility Quality Assurance meetings for the next quarter. Goal is to obtain 100% compliance by Q3, September 2021.

Completion Date: *04/23/2021*

Document Submission **Implemented**

Housekeeping, maintenance, and vendors have been notified of 2600.85e. Attached you will find notification letter sent to vendors, which is also now posted in loading dock area.

101o - Walls, Floors, Ceilings

1. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

101o - Walls, Floors, Ceilings *(continued)*

Description of Violation

On 04/23/21, the wall in bedroom [redacted], that is near to the residents bed is in disrepair, it has a hole in it.
On 04/23/21, the wall in bedroom [redacted] in Monarch Way Dementia Unit, is in disrepair, it has small holes on the side of the mirror, also the bathroom wall has an crack along the side of the ventilation cover.

Plan of Correction **Accept**

#5E

Deficiency: 2600.101.o. The bedrooms must have walls, floors and ceilings, which are furnished, clean and in good repair. *Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Work orders have been placed to address concerns in resident rooms. The patch for room [redacted] was completed on 4/26/2021. A plan being is established with General Services to complete a refresh of room [redacted] to ensure holes are patched and room is painted as appropriate. Room [redacted] refresh is to be completed by 5/21/2021.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Weekly environmental rounds to be completed with General Services and Housekeeping to ensure ongoing compliance with this regulation.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Weekly environmental rounds to be completed to ensure ongoing compliance. Re-education will be completed with team members to ensure concerns are reported to General Services and areas of concern are corrected in a timely manner.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Audit findings will be included and reported on in facility Quality Assurance meetings for the next quarter. Goal is to obtain 100% compliance by Q3, September 2021.

Completion Date: *05/21/2021*

Document Submission **Implemented**

Work order was completed for room [redacted] on 4/26/2021 (please see attached documentation). Work order for room [redacted] was completed on 5/17/21 (Please see attached document. In-services completed with Personal Care and Memory Care team.

185a - Implement Storage Procedures

1. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The following documentation errors were observed for resident #20:

On 04/22/21, at 8:00 p.m., glucometer reads 327, medication administration record (MAR) is documented as 333.

On 04/16/21, at 8:00 p.m., glucometer reads 255, MAR documented as 288.

On 04/15/21, at 8:05 p.m., glucometer reads 147, MAR documented as 197.

On 04/15/21, at 11:47 a.m., glucometer reads 340, reading was not documented on the MAR.

On 04/15/21, at 7:13 a.m., glucometer reads 367, MAR documented as 146.

On 04/14/21, at 7:51 a.m., glucometer reads 251, MAR documented as 170.

On 04/10/21, at 7:38 a.m., glucometer reads 283, MAR documented as 276.

On 04/09/21, at 9:30 a.m., glucometer reads 216, MAR documented as 218.

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

#6F

Deficiency: 2600.185.a. The home shall developed implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. *Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident #20's glucometer was replaced immediately with a new machine. Staff have been educated on this regulation and have been asked to transcribe glucometer information as presented on the machine.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Nurses to include glucometer checks as part of daily medication cabinet audits. Resident glucometers on Personal Care were reviewed on 4/23/2021 with no additional violations noted.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Nurses to include glucometer checks during daily medication cabinet audits to assure accuracy of transcription. Staff to be educated during forthcoming monthly team meetings to ensure the team is understanding of this regulatory requirement.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Audit findings will be included and reported on during facility Quality Assurance meetings for the next quarter. Goal is to obtain 100% compliance by May 31, 2021.

Completion Date: *04/23/2021*

Document Submission **Implemented**

Education provided during May 2021 monthly team meeting (Please see attached). Nurses to complete glucometer audits.