Department of Human Services
Bureau of Human Service Licensing

June 8, 2022

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

RE: MARIS GROVE
500 MARIS GROVE WAY
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 04/11/2022, 04/12/2022, 04/15/2022, 04/18/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

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:** *03/11/2023*

Address: *500 MARIS GROVE WAY, GLEN MILLS, PA 19342*

County: *DELAWARE* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *6103874833* **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-1* **Date:** *06/09/2009* **Issued By:** *concord twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *58* **Waking Staff:** *44*

Inspection Information

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Incident* **Exit Conference Date:** *04/18/2022*

Inspection Dates and Department Representative

04/11/2022 - On-Site: [redacted]
04/12/2022 - Off-Site: [redacted]
04/15/2022 - Off-Site: [redacted]
04/18/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *29*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Monarch 1 & 3* **Capacity:** *44* **Residents Served:** *29*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *29*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *29* **Have Physical Disability:** *0*

Inspections / Reviews

04/11/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/01/2022*

05/13/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/10/2022*

06/08/2022 - Document Submission

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan for resident 1, dated [redacted], indicates that the resident requires assistance with medication administration and incontinence care. On the 11pm-7am shift beginning on 3/26/22, the resident did not receive this assistance as required.

The assessment and support plan for resident 2, dated [redacted], indicates that the resident requires assistance with incontinence care. On the 11pm-7am shift beginning on 3/26/22, the resident did not receive this assistance as required.

Plan of Correction ***Accept***

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?

ADL care was provided to the residents on the morning of 3/28/22. Skin checks were completed to ensure the effected residents skin integrity remained at baseline.

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 Personal Care Home conducted interviews with both Staff Member A and Staff Member B that worked the 11-7 shift in question on 3/27/22. During the interview process both caregivers were asked to detail the care they provided and to which residents to identify if other residents were affected by the deficient practice. No other residents were identified beyond the three residents noted in inspection summary. Additionally, the Personal Care Home suspended the employee pending investigation and later separated employment due to the deficient practices.

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

The Personal Care Home had recognized the need for clearer assignments and the Personal Care Home Administrator, with input from the clinical team, had developed and begun the process of implementing shift assignment sheets. The Memory Care Nurses are responsible for completing the caregiver assignments for each shift. In the absence of a nurse pre-made sheets are available for each shift. The assignment sheets were fully implemented on all shifts as of 3/30/22. The new Staff Assignment sheets and process were reviewed in the Monthly Staff meetings on 3/16/22 and 3/30/22. Additionally, the Nurses of the Personal Care Home were in-serviced on their role in implementing and completing the assignment of the CAM's for all three shifts. The Personal Care

23a - Activities of Daily Living Assistance (continued)

Administer or Designee will conduct weekly audits of the staff assignment sheets for all 3 shifts for 4 weeks.

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 monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *05/31/2022*

Document Submission ***Implemented***

please see attached

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On Saturday, 3/26/22 during the 11pm to 7am shift, staff A and staff B were assigned to the 3rd floor SDCU. At approximately 2:25am, staff B noticed that resident 3's call bell had been ringing for more than 15 minutes. Staff B began to look for Staff A who was assigned to that resident. Staff A could not be located in any part of the building and was not seen again until approximately 7:10am. At the conclusion of the shift, staff B reviewed the medication records to find that resident 1, assigned to staff A, was not administered any of the prescribed medications. When staff B went to check on residents 1 and 2, [redacted] also found that both residents' incontinence products were soaked with urine.

Plan of Correction ***Accept***

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?

Both residents were assessed due to the deficient practice during the 11-7 shift on 3/27/22. Upon assessment no skin concerns or adverse effects noted related to missed medications or care.

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 Personal Care Home conducted interviews with both Staff Member A and Staff Member B who worked that evening to identify if other residents were affected by the deficient practice. No other residents were identified beyond the three residents noted in inspection summary.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?
The Personal Care Home had recognized the need for clearer assignments and the Personal Care Home

42b - Abuse (continued)

Administrator, with input from the clinical team, had developed and begun the process of implementing shift assignment sheets. The Memory Care Nurses are responsible for completing the caregiver assignments for each shift. In the absence of a nurse pre-made sheets are available for each shift. The assignment sheets were fully implemented on all shifts as of 3/30/22. The new Staff Assignment sheets and process were reviewed in the Monthly Staff meetings on 3/16/22 and 3/30/22. Additionally, the Nurses of the Personal Care Home were in-serviced on their role in implementing and completing the assignment of the CAM's for all three shifts. The Personal Care Administer or Designee will conduct weekly audits of the staff assignment sheets for all 3 shifts for 4 weeks.

The Personal Care Home Administrator or Designee will in-service Memory Care Caregivers on Abuse, Abuse Reporting and Abuse Prevention. The Personal Care Home suspended the employee pending investigation and later separated employment due to the deficient practices.

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 monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *05/31/2022*

Document Submission ***Implemented***

please see attached

42v - Resident-Home Contract

1. Requirements

2600.
42.v. A resident has the right to receive services contracted for in the resident-home contract.

Description of Violation

From 3/26/22 at 11pm until 3/27/22 at 7am, the home failed to provide medication administration services and incontinence care to resident 1, as contracted for in the resident-home contract.

From 3/26/22 at 11pm until 3/27/22 at 7am, the home failed to provide incontinence care to resident 2, as contracted for in the resident-home contract.

Plan of Correction ***Accept***

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?

Both residents were assessed due to the deficient practice during the 11-7 shift on 3/27/22. Upon assessment no skin concerns or adverse effects were noted related to missed medications or care.

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

42v - Resident-Home Contract (continued)

corrective action will be taken?

The Personal Care Home conducted interviews with both Staff Member A and Staff Member B who worked that evening to identify if other residents were affected by the deficient practice. No other residents were identified beyond the three residents noted in inspection summary.

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

The Personal Care Home had recognized the need for clearer assignments and the Personal Care Home Administrator, with input from the clinical team, had developed and begun the process of implementing shift assignment sheets. The Memory Care Nurses are responsible for completing the caregiver assignments for each shift. In the absence of a nurse pre-made sheets are available for each shift. The assignment sheets were fully implemented on all shifts as of 3/30/22. The new Staff Assignment sheets and process were reviewed in the Monthly Staff meetings on 3/16/22 and 3/30/22. Additionally, the Nurses of the Personal Care Home were in-serviced on their role in implementing and completing the assignment of the CAM's for all three shifts. The Personal Care Administer or Designee will conduct weekly audits of the staff assignment sheets for all 3 shifts for 4 weeks.

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 monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *05/31/2022*

Document Submission ***Implemented***

please see attached

187d - Follow Prescriber's Orders

1. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 1 is prescribed Memantine 10 mg tablet, Aspirin 81 mg chewable tablet, Vitamin B-12 1,000 mcg tablet, trazadone 50 mg tablet, and Tylenol 325 mg tablet. However, resident 1 was not administered any of the medications on 3/27/22 at 06:30AM.

Plan of Correction ***Accept***

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?

Upon discovery of the deficient practice an investigation with Clinical Leadership was initiated. The resident's

187d - Follow Prescriber's Orders (continued)

Medical Provider and family were notified of the missed medications. No new orders were received from the physician at that time.

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 Personal Care Home conducted interviews with both Staff Member A and Staff Member B who worked that evening to identify if other residents were affected by the deficient practice. No other residents were identified beyond the three residents noted in the inspection summary. Additionally the Personal Care Home Administrator did a Medication Administration Record (MAR) review for the residents in rooms 332-342 under Staff Member A's care on the evening on 3/27/22 to identify if other residents went without their medications administered per the Physician's orders. No other residents were identified as having missed medications on 3/27/22.

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

The Personal Care Home had recognized the need for clearer assignments and the Personal Care Home Administrator, with input from the clinical team, had developed and begun the process of implementing shift assignment sheets. The Memory Care Nurses are responsible for completing the caregiver assignments for each shift. In the absence of a nurse pre-made sheets are available for each shift. The assignment sheets were fully implemented on all shifts as of 3/30/22. The new Staff Assignment sheets and process were reviewed in the Monthly Staff meetings on 3/16/22 and 3/30/22. Additionally, the Nurses of the Personal Care Home were in-serviced on their role in implementing and completing the assignment of the CAM's for all three shifts.
The Personal Care Home suspended the employee pending investigation and later separated employment due to the deficient practices. The Personal Care Administer or Designee will conduct weekly MAR reviews for all 3 shifts for four weeks in addition to the biannual MAR reviews required as part of the Medication Technician annual 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 monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *05/31/2022*

Document Submission ***Implemented***

please see attached