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

October 16, 2023

[redacted], NHA
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 07/24/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MARIS GROVE* **License #**: *13466* **License Expiration**: *03/11/2024*

Address: *500 MARIS GROVE WAY, 1ST AND 3RD FLOORS, GLEN MILLS, PA 19342*

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

Administrator

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

Legal Entity

Name: *MARIS GROVE INC*

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

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *07/19/2022* **Issued By**: *Concord Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *88* **Waking Staff**: *66*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *07/24/2023*

Inspection Dates and Department Representative

07/24/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Rose Court* **Capacity**: *66* **Residents Served**: *44*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *44*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *44*

Have Physical Disability: *0*

Inspections / Reviews

07/24/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/26/2023*

09/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/02/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/19/2023*

Inspections / Reviews *(continued)*

09/22/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/02/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/06/2023*

10/16/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/02/2023*

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

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 [redacted] Staff person A noticed skin tears and dried blood on the hand of resident #1. Staff person A reported this to staff person B and staff person C. The staff inquired with resident #1 about what happened to [redacted] hand. Resident #1 reported that [redacted] had fallen and a "larger woman" helped him up. Resident #1 communicated that they asked for a band aid. Staff person D responded with "I have other things to do."
Staff person D neglected to report the information to the nurse at 3:00am when the incident occurred, and failed to render first aid to resident #1.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

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?

On [redacted], Staff Member A noted two skin tears with dried blood on the hand of Resident 1. Staff Member A immediately reported the concern to Nursing team members, Staff Member B and Staff Member C. Care was immediately provided by Staff Person B and an investigation was initiated. The Director of Nursing, Assistant Director of Nursing, the Memory Care Wellness Manager (Staff Member C) and the Human Resources Manager interviewed and immediately suspended Staff Person D on [redacted] pending investigation.

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 [redacted] when Director of Nursing, Assistant Director of Nursing, the Memory Care Wellness Manager (Staff Member C), and the Human Resources Manager were notified of the concern the team immediately conducted interviews with Staff Member D and all the 11-7 team members who worked with Staff Member D on [redacted]. Additionally, no further concerns were noted by Staff Member A when completing care on [redacted] or by any other 7-3 staff members working on [redacted] Personal Care Home did not identify any other residents affected by the deficient practice.

What measures will be put into place or what system changes will you make to ensure that the deficient practice

42b - Abuse (continued)

does not recur?

Staff Person D was immediately suspended on [redacted] pending investigation. The Personal Care Home later separated employment due to the deficient practice. The Personal Care Home Administrator or designee will in-service the Memory Care team on provision of care after an injury, Incident Report completion and reporting. Target date for completion of the in-services will be August 31, 2023.

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 of incident report procedures and completion will be monitored by the Personal Care Administrator or designee monthly through our facility Quality Assurance/Performance Improvement program for the next 3 months starting in October 2023.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 10/16/2023)

60a - Staff/Support Plan

2. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 12-30-22, at 4:55am during the overnight drill, documentation shows there were 44 residents and 1 staff. The following residents have concerns with ambulation and mobility.

- *Resident # 1 requires assistance with ambulation and utilizes an assistive device*
- *Resident # 2 requires assistance with ambulation and transferring in and out of the bed.*
- *Resident # 3 requires assistance with ambulation and utilizes an assistive device.*

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

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?

The Personal Care Home has provided documentation to reflect that the staffing was within 2600 regulations however was not documented correctly by the Fire Consultant Company who document's the Personal Care Home's fire drills. The Fire Consultant Company was contacted and an updated Fire Drill record was requested to include the correct reflection of the Personal Care Home's staffing for the fire drill dated 12/30/22 as noted on the Personal Care Home's Daily schedule and time keeping records for 12/29/22.

60a Staff/Support Plan (continued)

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 Administer and Memory Care Wellness Manager did not identify any other residents effected as the citation is based on a documentation error and not an accurate reflection of staffing on the 11 7 shift on 12/29/22 into 12/30/22.

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 Administrator has requested the Supervisor of the Fire Consultant Company will review the Fire Report documentation prior to sending the documentation to ensure documentation is specific to the 2600 regulations on Fire Drill Reports. The Personal Care Administrator or Designee will review the Fire Drill Report documentation monthly for compliance and request changes as needed for inaccurate or incomplete documentation. Additionally, Staffing Schedules are reviewed daily by the Personal Care Home Administrator or designee and members of the Nursing leadership team to ensure adequate staffing in accordance with the 2600 Regulations and in Support of the Memory Care resident's needs based on their Resident Assessment and Support Plans (RASP).

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?

Fire Drill Documentation Compliance will be monitored by the Personal Care Administrator or designee monthly through our facility Quality Assurance/Performance Improvement program for the next 3 months starting in October 2023.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 10/16/2023)