STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395345	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Rehabilitation & Healthcare Center	615 Wyoming Avenue Kingston, PA 18704

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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interview, it was determined the facility failed to consistently implement planned interventions and provide necessary treatment and services to prevent the worsening of a pressure ulcer for one resident out of four residents sampled for pressure ulcer care (Resident CR1) resulting in the worsening of a Stage 2 pressure ulcer to an unstageable pressure injury, constituting actual harm. Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists who specialize in the diagnosis, treatment, and care of adults. Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Review of the facility policy titled Prevention of Pressure Injuries, provided on May 1, 2025, indicated the facility will review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The facility will inspect the skin on a daily basis when performing or assisting with personal care or ADLs (activities of daily living) and reposition the resident as indicated on the care plan. The facility will reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team and choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. Additionally, monitoring of area(s) will include evaluation, report, and documentation of potential changes in the skin, and a review of interventions and strategies for effectiveness on an ongoing basis. (continued on next page)

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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F 0686 Level of Harm - Actual harm Residents Affected - Few	A clinical record review revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors), dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and need for assistance with personal care. A review of Resident CR1's admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 30, 2025, revealed that Resident CR1 was severely cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment), and required total staff assistance for activities of daily living, rolling in bed, and transfers; and was moderately at-risk for the development of pressure ulcers and injuries. Section M: Skin Conditions, indicated that Resident 18 had a stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose or fat tissue is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present) upon admission to the facility. According to the MDS the resident utilized an indwelling urinary catheter but was always incontinent of bowels. A review of the resident's care plan initiated March 25, 2025, identified a focus area related to skin integrity with planned interventions which included application of protective barrier cream after incontinent episodes and as needed, assist resident with turning and repositioning as needed, complete skin inspection every 7 days and as needed, complete wound evaluation to monitor the progress of the resident's skin condition, encourage/assist resident as needed to elevate heels off the mattress, pressure reducing air cushion to chair, and provide treatments as per physician orders. A review of Resident CR1's clinical record revealed an initial wound evaluation dated March 25, 2025, at 7:28 PM, which revealed the resident was admitted to the facility with a Stage 2 pressure ulcer on the sacrum that measured 2 cm x 2 cm x < 0. 1cm with no drainage and no odor present in the wound bed. The peri wound (skin area surrounding the wound) appearance was red in color. Review of a Skin and Wound note dated March 26, 2025, at 1:57 PM, completed by the wound care consultant, indicated the pressure area was on Resident CR1's right intergluteal fold (the vertical groove between the buttocks). The wound was classified as a stage 2 that measured 0.5 cm x 0.4 cm x 0.1 cm, was 100% epithelialized (entire surface of wound is covered by new skin tissue) with scant amount of serous drainage (clear, thin, watery fluid that is a normal part of the healing process). Treatment recommendations were to cleanse with soap and water, pat dry; apply Renew Peri Protect (specific barrier cream used to protect the skin from moisture) to the base of the wound every shift and as needed, provide swift incontinence management, provide an alternating air/low air loss mattress for pressure redistribution, and provide ongoing turning/repositioning precautions. Review of a Skin and Wound note dated April 2, 2025, at 2:06 PM, completed by the wound care consultant, indicated the stage 2 pressure area on the right intergluteal fold measured 0.5 cm x 0.4 cm x 0.1 cm and continued to be 100% epithelialized with a scant amount of serous drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment recommendations included to cleanse with soap and water, pat dry, apply Renew Peri Protect to the base of the wound every shift and may be applied after each incontinence episode, provide swift incontinence management, keep resident off his bottom as resident will allow, and turn the patient side to side as tolerated. Despite these interventions being documented in wound care recommendations and the resident's care plan, a review of the Treatment Administration Records (TAR) for March and April 2025 failed to reveal documentation that Renew Peri Protect was ordered or applied as recommended by the wound care consultant on March 26, 2025, and April 9, 2025. Additionally, review of Resident CR1's Documentation Survey Report v2 (reports that capture care-related tasks completed by nurse aides) for March and April 2025 did not show evidence that staff consistently turned and repositioned the resident as per the plan of care and wound consultant's instructions. Review of Skin and Wound note dated April 9, 2025, at 2:06 PM, completed by the wound care consultant, documented the right intergluteal fold wound significantly worsened and spread across the sacral region. The pressure wound was now classified as an unstageable wound (type of wound where the base of the wound is obscured by slough, a yellow/white material consisting of dead cells or eschar, a dry, hard, leathery dead tissue in the wound bed, making it impossible to determine the true depth and stage of the wound) measuring 7.5 cm x 2.5 cm x 0.2 cm. The wound base was 40% slough with a moderate amount of serous drainage. Treatment recommendations included application of Renew Peri Protect every shift and apply after each incontinence episode, increase frequency of incontinence management due to new onset of diarrhea, keep off bottom, and turn the resident side to side every 2 hours and as needed. Although the wound had significantly declined, no new or intensified treatment interventions were initiated beyond reiterating the prior recommendations. Skin inspections were documented on April 1, 2025, and April 8, 2025, however, there were no wound measurements recorded for Resident CR1's sacral pressure area to evaluate whether the pressure ulcer was healing, worsening, or remaining unchanged. Facility policy indicated that wounds would be monitored to determine any potential changes. The lack of consistent wound measurements had the potential to prevent accurately evaluating the effectiveness of the treatment plan and adjusting interventions as necessary. Interview with the Director of Nursing on May 1, 2025, at approximately 12:45 PM, confirmed the facility could not provide evidence the treatment interventions ordered by the wound care consultant were implemented, including use of the barrier product or that new treatment interventions were developed after the decline in the wound was identified. The facility could not provide evidence of a consistent turning and repositioning schedule or that facility staff thoroughly evaluated Resident CR1's sacral pressure ulcer for worsening and/or improvement. There was no evidence the worsening of the wound was met with an updated plan of care or intensified interventions. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1)(3) Management 28 Pa. Code 201.29 (a)(c) Resident Rights (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services