

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Markley Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 550 East Fornance Street Norristown, PA 19401	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, facility documentation, and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect during a mechanical lift transfer for one of seven residents reviewed (Resident R1).</p> <p>Findings Include:</p> <p>Review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 states, Policy Statement- Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation- The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff b. other residents.</p> <p>Review of facility policy titled, Assessment of Skin Condition and Integrity dated March 2021 states, Purpose- The purpose of this policy is to provide information regarding the routine assessment of skin integrity. Skin Assessment- 1. Conduct a comprehensive head-to-toe skin assessment upon admission, weekly, prior to discharge, and as needed. a. During the skin assessment, inspect for: i. Presence of skin impairment(s); ii. Type of skin impairment(s); and iii. Location of skin impairment(s); 2. Inspect the skin daily when performing or assisting with personal care or ADLs.</p> <p>Review of facility records revealed Resident R1 was admitted to the facility on [DATE] with the following diagnosis: Heart Failure (chronic condition where the heart doesn't pump blood as well as it should), Hyperlipidemia (high levels of fats in the blood), Hypothyroidism (underactive thyroid), Lymphedema (swelling), Body Mass Index 40.0-44.9, Bradycardia (slow heart rate), Anxiety Disorder (feelings of nervousness), and abnormalities of gait and mobility.</p> <p>Review of facility documentation dated May 2, 2025 at 11:00 a.m. revealed, Injuries- Bruise- left thigh 12 x 10 cm and rule out fracture- left elbow . Resident stated she was lowered to floor in hoyer as one of the loops got loose and began to slide down</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility investigation documentation revealed a witness statement dated May 2, 2025 from nurse aide Employee E3 stating, As I was lifting the resident off the bed to her chair. One of the sling loop on the left of her leg slip-off hitting her left leg first on the floor, and then the whole left side and the whole body slid off the lift slowly to the floor. The statement states, How were you lifting? By the hoyer. How far was she off the bed? About two feet. Was she still over the bed when the sling came loose? Half was to her chair. Who helped you with the hoyer? Just me.</p> <p>Radiology results documentation from May 2, 2025 revealed that the resident was sent out to the hospital for an x-ray of the left elbow with three views. Results showed no fractures of dislocations.</p> <p>Review of Witness Statement from May 3, 2025 revealed, Met with [Resident R1] in the presence of her son. Asked resident how she was doing and apologized for what had occurred. Resident said elbow hurts and son said left leg and butt bruised. Asked resident to complete a statement. Resident did not wish to do so at the time. I said I would check back with her on Monday May 5. Resident's son requested a copy of the incident report and a copy of the x-ray that was done in house. Resident handed me discharge paperwork from the hospital and I gave to the nurse. Resident was not pleased with the hospital as she was there for twenty-four hours and was given no breakfast. Resident and son very pleasant. Resident offered that aide was very good.</p> <p>Review of Witness Statement from May 5, 2025 revealed, Met with [Resident R1] this morning. She said that she was not in pain upon my asking. She expressed being happy to be out of bed and was planning on visiting the gym when her kids arrived. She does not wish to complete a written statement. She stated that the aide has been providing her with care since she first came here and that she has never had a problem and that he usually has someone with him when using the lift.</p> <p>Review of Resident R1's clinical record revealed several Weekly Skin Checks completed. Review of a Weekly Skin Check completed on May 6, 2025. Review of the Weekly Skin Check revealed Section 1a. Are there any skin impairments noted? -Yes is checked. Section 1c.-Type of Skin Impairment is left blank. Section 1d.-Body Diagram is also left blank with no description.</p> <p>Review of a Weekly Skin Check was completed on May 13, 2025. Review of the Weekly Skin Check revealed Section 1a. Are there any skin impairments noted? -Yes is checked. Section 1c.-Type of Skin Impairment is listed as Bruise. Section 1d.-Body Diagram listed Lower Left Extremity.</p> <p>Review of a Weekly Skin Check was completed on May 13, 2025. Review of the Weekly Skin Check revealed Section 1a. Are there any skin impairments noted? -Yes is checked. Section 1c.-Type of Skin Impairment is listed as Bruise. Section 1d.-Body Diagram listed Lower Left Extremity.</p> <p>Review of a Weekly Skin Check was completed on May 21, 2025. Review of the Weekly Skin Check revealed Section 1a. Are there any skin impairments noted? -Yes is checked. Section 1c.-Type of Skin Impairment is listed as Bruise. Section 1d.-Body Diagram listed Lower Left Extremity.</p> <p>Review of a Weekly Skin Check was completed on May 28, 2025. Review of the Weekly Skin Check revealed Section 1a. Are there any skin impairments noted? -Yes is checked. Section 1c.-Type of Skin Impairment is listed as Bruise. Section 1d.-Body Diagram listed Upper Extremity, Lower Extremity.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was held on June 18, 2025 at 12:53 p.m. with licensed nurse Employee E4 to discuss interim pain evaluation and Interim Skin Check completed by her on May 2, 2025. Employee E4 was asked about the Interim Skin Check that was completed by her for Resident R1 post fall. Employee E12 stated that she was the unit manager of the second floor that day. Employee E12 and licensed Nurse Employee E14 went into the room of Resident R1 after being called to the room by nurse aide Employee E3. When Employee E12 entered the room she stated she say the hoyer by Resident R1 and nurse aide Employee E3 also in the room. Employee E12 stated that Resident R1 had stable vital signs but that she was complaining of left hip pain and pain in her left arm area. Licensed nurse Employee E14 was called to complete an assessment also. Employee E12 stated that the physician was also at the facility and evaluated the resident right away. When asked about the Description and Body Diagram sections of the Skin Evaluations to be completed by nurses at the facility the licensed nurse, Employee E12 stated that sometimes, the numbers are used for reference or measurements, words can be noted where description is listed on the evaluation. When Employee E12 was asked where lower left extremity pain would be noted the staff pointed/indicated areas between 34 and 38 on the picture description (upper left thigh and hip area).</p> <p>Interview held on June 17, 2025 at 1:00 p.m. with licensed nurse Employee E14. Employee E14 was asked to discuss how she became aware of Resident R1 having a fall. Employee E13 stated that she was Resident R1's nurse on May 4, 2025 when nurse aide Employee E3 came to her with a look. Employee E14 stated, he never looks upset, and he looked upset so I asked what was wrong, and if someone fell and he shook his head yes. I went into the room, and I saw Resident R1 on the floor with the hoyer pad under her, nurse aide Employee E3 in the room, the mechanical lift was in the room, and one strap was not strapped in all the way.</p> <p>Nurse aide Employee E3 was called on June 17, 2025 at 12:02 p.m. but did not answer the phone.</p> <p>Interview on June 17, 2025 at 1:44 p.m. held with the Director of Nursing Employee E2 regarding skin assessment revealed staff at times do use to the Body Diagram and Descriptions section for the Skin Assessments. When asked where they would describe Lower Left Extremity pain, the Director of Nursing, Employee E12 pointed to the right lower leg/ankle area numbers 34 to 38 on the diagram.</p> <p>Interview with the Regional Nurse Employee E5 on June 17, 2025 at 10:49 a.m. confirmed that nurse aide Employee E3 did use the mechanical lift by himself in attempt to unsafely transfer the resident, when he should have had a second staff to help assist him with moving the Resident R1 from her bed to the wheelchair.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interview with staff it was determined the facility did not maintain medical records according to professional standards for one of seven residents reviewed. (Resident R2).</p> <p>Findings Include:</p> <p>Review of facility policy Guidelines for Charting and Documentation with a revision date of April 2021 states, Purpose- The purpose of charting and documentation is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care; 2. Guidance to the physician in prescribing appropriate medications and treatments; 3. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident; 4. Nursing service personnel with a record of the physical and mental status of the resident; 5. Assistance in the development of a Plan of Care for each resident; 6. A legal record that protects the resident, care providers, and the facility; and 7. A source of all resident charges. Further review of the policy revealed, General Rules for Charting and Documentation 1. Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observations. 2. Be concise, accurate, and complete and use objective terms. Avoid brief, monotonous, and meaningless entries. 3. Document only the facts. Do not document interpretive statements or opinions, unless authorized or designated to do so. 4. Use only approved abbreviations and symbols. 5. Chart as often as necessary and as the need arises.</p> <p>Review of Resident R2's clinical record revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Multiple Sclerosis (disease of the immune system), Muscle Wasting with Atrophy (loss of muscle mass), Acute Respiratory Failure with Hypoxia,</p> <p>Review of information submitted to the State Survey Agency completed for Resident R2 when the resident alleged that sexual abuse occurred in 2024 by a nurse aide.</p> <p>Review of General Incident Witness Statement by licensed nurse Employee E10 dated February 4, 2025 revealed, The resident expressed to this nurse he wanted to talk about a situation that happened months ago. The resident consistently asks this nurse to come to his room for urgent matters however the resident proceeds to talk about non-urgent matters such as which aide he prefers over another or how unattractive a certain aide is, at which time this nurse tells the resident such conversation is not appropriate or urgent. Around 2:30 p.m. the resident came to the nurses station demanding to speak to this nurse, at which time he states, since your taking so long I'm calling the police. Resident states he believes he was sexually assaulted by the aide (Employee E8) around October or November. This nurse notified social worker met with resident in his room where the resident stated, the aide pulled out my penis with no gloves and began to fondle me Social worker called 911 emergency line, and protective services. This nurse notified the nurse practitioner and was given no new orders. Place resident R2 on paired care at all times.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of General Incident Witness Statement by licensed nurse Employee E11 dated February 5, 2025 revealed, On November 18, 2025 or anytime in October and up to February 3, 2025 did Resident R2 reported being sexually assaulted by nurse aide Employee E8? No never on November 18, 2024. Employee E8 reported that he was making her uncomfortable, I spoke to Resident R2 he denied being inappropriate and he was made paired care. He never reported being sexually assaulted by her ever.</p> <p>Review of facility investigation revealed several General Incident Witness statements from staff containing information that was not documented in the Resident R2's clinical record.</p> <p>Review of General Incident Witness Statement from licensed nurse Employee E7 dated February 5, 2025 revealed, This nurse is assigned to administer medications to this resident (Resident R2) three days a week. Resident often makes inappropriate and offensive remarks. This nurse attempts to redirection with every behavior but resident becomes defensive, angry, and is non-remorseful. Resident brought me a box with a cellphone and told me that it is for me to text him when my boyfriend is not around. This nurse refused the phone and explained to the resident that his actions were inappropriate. Resident then bought this nurse flowers that were also refused and left at the facility. When administering medications to the patient he stated, If you put lotion on my butt, I will let you look at my penis. This nurse immediately told the resident that his behavior was inappropriate and not acceptable. When administering medication to the resident he often attempted to touch/grab my hand. This nurse began placing medication and water on bedside table and watching him take it.</p> <p>Review of General Incident Witness Statement written by licensed nurse Employee E9 on dated November 18, 2025 but signed February 2, 2025 (verbal) revealed, During my 3-11 shift nurse aide Employee E8 came up to me and told me that the resident was making inappropriate remarks to her and she felt uncomfortable, I told her to go to the charge nurse and report her experience.</p> <p>Review of General Incident Witness Statement by licensed nurse Employee E7 dated November 18, 2024 revealed, During my 3-11 shift, Employee E8 came to the nurses station where I was sitting and stated that the resident (resident R2) was making inappropriate remarks while she was in the room/during care and was making her feel uncomfortable. This nurse told the supervisor and resident was made paired care immediately with no other issues for the rest of the shift.</p> <p>Review of Resident R2's clinical record revealed from November 12, 2024 through November 19, 2025 there were no nursing notes documenting inappropriate sexual behaviors. Further review of Resident R2's notes from January 22, 2025 through January 29, 2025 there were nuring notes addressing inappropriate sexual behaviors.</p> <p>28 Pa. Code 211.5 (f)(ii) Medical records</p> <p>28 Pa. Code 211.12(c) Nursing services</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on review of personnel records and interviews with staff, it was determined that the facility failed to ensure that nurse aides received at least 12 hours of in-service education per year as required for two of six nurse aide personnel files reviewed (Employee E3 and Employee E8).</p> <p>Findings Include:</p> <p>Review of facility employee record for nurse aide Employee E3 revealed the employee was hired on July 23, 2004. Review of Employee E3 record revealed the resident did not have a total of twelve hours of continued education for the year 2024 and 2025. Further review of the employees training record revealed Employee E3 had not had Abuse training completed since March 16, 2024.</p> <p>Review of nurse aide Employee E3's personnel file revealed that the employee was hired on on July 23, 2004. , as a nurse aide. Continued review revealed that nurse aide, Employee E3 did not have any Abuse training completed for the year of 2025. The last Abuse training complete by nurse aide Employee E3 was on March 16, 2024. The facility was asked if nurse aide Employee E3 had any additional training for the years 2024 and 2025. The facility was given additional time to provide documentation or in servicing and the facility was unable to provide. Further review of nurse aide Employee E3's training record revealed no trainings completed for mechanical lifts. The facility was asked to provide documentation that Employee E3 was trained and competent in mechincal lifts and the facility was unable to provide this documentation.</p> <p>Review of facility training documentation provided by the facility revealed nurse aide Employee E8's personnel file had half an hour of Abuse training on November 7, 2024.The facility was given additional time to provide documentation or in servicing and the facility was unable to provide.</p> <p>Interview on June 18, 2025, at 2:52 p.m. the Employee E2 Director of Nursing confirmed that the facility could not provide proof that nurse aide, Employee E3, had completed 12 hours of annual in-service education as required.</p> <p>Further review was made of additional employee personnel files for nurses and the investigation revealed two nurses did not have up to date abuse trainings.</p> <p>Review of facility training documentation provided by the facility revealed licensed nurse Employee E12 was hired on June 15, 2021. Review of facility training documentation revealed Employee E12 is still currently employed and the last had Abuse training for the employee was completed on February 16, 2024.</p> <p>Review of facility training documentation provided by the facility revealed licensed nurse Employee E13 was hired on July 7, 2021. Review of facility training documentation revealed Employee E13 is still currently employed and the last had Abuse training for the employee was completed on February 22, 2024.</p> <p>28 Pa Code 201.19(7) Personnel policies and procedures</p> <p>28 Pa Code 201.20(a) Staff development</p>		