STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395483	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Markley Rehabilitation and Healthcare Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of resident clinical record, observations and interviews with residents and staff, it determined that the facility did not timely update a resident's care plan to incorporate evolving clinical findings, resident preferences, and refusals of care for one of ten residents reviewed (Resident R1) Findings include: Review of the resident care plan policy titled Care Plans, Comprehensive Person Centered (Revised March 2022) revealed that a comprehensive, person-centered care plan must be developed and implemented for each resident. This care plan is required to include measurable objectives and timetables to address the resident's physical, psychosocial, and functional needs. It must describe the services necessary to attain or maintain the resident's highest practicable level of physical, mental, and psychosocial well-being. The plan should also account for services that may not be provided due to the resident exercising their rights, including the right to refuse treatment. Additionally, it must outline any specialized services required based on past assessments or professional recommendations and identify the professionals responsible for each aspect of care. The care plan should incorporate the resident's stated goals, build on their strengths, and reflect current recognized standards of practice for managing their specific conditions and problems. Resident assessments are ongoing, and care plans must be revised promptly as new information about the resident's condition becomes available or as their needs change. Review of Resident R1's admission Minimum Data Set (MDS), a federally mandated assessment tool for all residents, revealed that Resident R1 was admitted to the facility on [DATE]. At admission, the resident had a cognitive BIMS score of 15, used a wheelchair, and was independent with most activities. The resident's diagnoses included anemia (a condition characterized by a lack of healthy red blood cells to carry adequate oxygen to body tissues), peripheral vascular disease (PVD), which affects blood vessels outside the heart and brain-typically in the legs-caused by narrowing or blockage due to fatty deposits, leading to reduced blood flow, leg pain with walking (claudication), numbness, and slow-healing wounds. Other diagnoses were diabetes, a chronic condition affecting blood sugar processing, with main types including Type 1, Type 2, and gestational diabetes; arthritis, an inflammatory joint condition causing pain, swelling, stiffness, and limited motion; cellulitis of the lower limb, a bacterial skin infection affecting deeper layers of skin and underlying tissue; narcolepsy, a chronic neurological disorder impacting sleep-wake regulation, causing excessive daytime sleepiness and sudden sleep episodes; Sjogren's syndrome, a chronic autoimmune disease where the immune system attacks moisture-producing glands; vasculitis, inflammation of blood vessels causing thickening, weakening, narrowing, or scarring that can restrict blood flow and damage organs and tissues; and a history of falls. Review of Resident R1's Wound Notes dated August 13, 2025 noted Resident evaluated in bed with staff for BLE (bilateral legs) wounds/vasculitis. New open areas noted on the left shin. BLE baseline pink discoloration. Resident reported a burning sensation from Hydrogel treatment. Toe dressings were off. Wound note dated September 10, 2025 revealed Resident examined at bedside with staff including DON (Director of Nursing), ADON (Assistant Director of Nursing), unit managers, and staff nurse. Resident reported self-ordering and applying dressings, described as ABD pads with tape and foam dressings. No treatment observed on BLE heels or great toes. Resident reported dressings frequently come off and expressed burning sensations with gauze treatment. Resident refused Dakin's cleansing, gauze, wound gel, and calcium alginate treatments citing burning sensations. Current treatment was Xeroform. Staff reported resident refusal of treatment changes, which the resident denied. Discussion with staff present revealed challenges in assessing treatment effectiveness due to resident removing prescribed dressings and self-applying unapproved dressings. Resident continues to use heels to self-propel wheelchair despite PCP (Primary Care Physician) recommendations for wheelchair leg lifts, which the resident does not use. Resident is inconsistent with compression therapy and declined heel lift boots. Review of the resident's care plan, initiated on August 25, 2025, revealed that the resident has skin breakdown and/or potential for skin breakdown related to cardiovascular disease, edema, a history of skin breakdown, impaired sensory perception, neuropathy, and vasculitis. Continued review of the resident's care plan failed to address interventions related to the resident purchasing own treatment supplies and risk and consequences of applying these treatments. 28 Pa. Code (d)(1) Nursing Services28 Pa. Code (c)(d) Resident Care Policies