STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396123	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Maris Grove	500 Maris Grove Way Glen Mills, PA 19342

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on clinical record reviews, staff interviews, and facility policy reviews, it was determined that the facility failed to implement the comprehensive care plan approaches to prevent accidents for one of eight residents reviewed. (Resident 208) Findings include: Review of facility policy Care/Service Plans, review date May 2021, indicated each resident will have an individualized care/service plan developed. Care/service plans will include resident preferences, strengths, routines, personal and cultural preferences and choices as well as clinical needs. All interdisciplinary team members will document any updates/changes on care plan copy in the guest/resident suite/apartment/designated accessible location and review update with designated care associate. Review of Resident 208's admission record indicated he/she was admitted to the facility on [DATE]. Review of Resident 208's admission record indicated diagnoses including but not limited to fracture of the lower end of left femur (hip fracture), iron deficiency anemia (lack of iron), abnormalities of gait and mobility (abnormal walking pattern), muscle weakness and osteoarthritis left shoulder (break down of cartilage and joint tissue). Review of Resident 208's clinical records revealed a care plan dated January 23, 2024, documenting the resident requires one-person physical assist with transfers. Review of a written witness statement dated March 18, 2024, from Nurse Assistant Employee E3 stated: I was washing him/her (Resident 208) in the shower chair and he/she started to slide down and broke the arm to the shower chair as she slid. As he/she was sliding down, he/she was kind of leaning to his/her left side as he/she fell . I was trying to pull him/her back up, but he/she was heavy weight, so I pulled him/her a bit from behind and I pushed the button to open the door and called for Nursing Assistant Employee E4. Nursing Assistant Employee E4 stated we don't usually give him/her a shower, he/she is a Hoyer, we give him/her a bed bath. I didn't know that. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documentation provided by the facility dated March 19, 2024, stated the following: Prior to submission of state reportable, electronic version of resident's last assessment was reviewed. This identified the resident as a 2 person assist with use of a Hoyer lift. Upon further review of documentation, and following submission of state reportable for neglect, it was identified the resident's plan of care paper copy detailed the resident's transfer status as assist of one person. Further review of Resident 208's clinical records revealed an updated care plan dated March 19, 2024, documenting the resident requires two-person assistance with Hoyer for transfers. During an interview on March 13, 2025, at 11:56 a.m. Physical Therapist (PT) Employee E7 confirmed that Resident 208 had required a two person assist with Hoyer for transfers since March 13, 2024, when a Post Acute Care/Care Plan review evaluation was completed. During an interview on March 13, 2025, at 12:14 p.m. when the above was presented, the Director of Nursing (DON) confirmed Resident 208 was a two person assist with Hoyer, but the paper copy of Resident 208's care plan, which was located at the nurse's station for staff review, was not updated and documented Resident 208 as one person assist failing to prevent an accident. 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.12(c) Nursing services

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166 Based upon clinical record review, it was determined the facility failed to complete discharge summary on the day of planned discharge for one of three residents reviewed (Resident 45). Findings include: Review of Resident 45's clinical record revealed Resident 45 was admitted to the facility on [DATE], and was discharged to home on March 3, 2025. Review of Resident 45's clinical record failed to reveal a discharge summary completed on March 3, 2024, the day of a planned discharge. The above information was conveyed to the Nursing Home Administrator on March 14, 2025, at 1:38 p.m. 28 Pa. Code 211.5(f) Clinical Records

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41765 Based on clinical records review and staff interview, it was determined that the facility failed to ensure the physician's order regarding medication was followed for one of the 16 residents reviewed (Resident 12). Findings include: A review of Resident 12's physician order dated May 29, 2024, revealed an order for Lorazepam (A medication to treat anxiety) 2mg/ml Give 1 mg (0.5ml) every 2 hours as needed for Anxiety sublingually (Medication administered under the tongue). A review of Resident 12's November 2024, Medication Administration records and controlled substance declining sheet revealed that instead of 0.5 ml, Resident 12 was administered 0.25 ml of Lorazepam on the following dates: November 2, 2024, at 2:53 p.m., November 7, 2024, at 2:39 p.m., November 9, 2024, at 3:50 p.m., and November 14, 2024, at 1:00 a.m. An interview with the Director of Nursing conducted on March 14, 2025, at 10:40 a.m., confirmed Resident 12's physician's order for as-needed Lorazepam was not followed on the dates listed above. The facility failed to ensure Resident 12's as-needed Lorazepam order was followed. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services

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(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 - Minimal harm or potential for 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** 41765 Based on clinical records review and staff interviews, it was determined that the facility failed to follow a wound specialist's recommendation for wound treatment for one of the two residents reviewed (Resident 25). Findings include: Clinical records review revealed Resident 25 was admitted to the facility on [DATE], for diagnosis of Congestive Heart Failure (CHF-A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). A review of the skin assessment revealed Resident 25 was admitted to the facility with a Stage 2 Pressure Ulcer (Partial-thickness skin loss with exposed dermis) to the sacrum (The triangular bone just below the lumbar vertebrae). Wound treatment was made and followed. A review of the wound consult dated February 3, 2025, revealed Resident 25's sacral wound progressed into an Unstageable Pressure Ulcer (Obscured full-thickness skin and tissue loss) measuring 1.5 x 0.7 cm with 100% slough (is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). The wound was debrided (A medical procedure that involves removing dead or infected tissue from a wound) by the physician. The recommended treatment was Calcium alginat (Are absorbent, non-adhesive dressings made from seaweed fibers used to mane moderately to heavy exuding wounds) with Honey and dry dressing. An interview with a wound nurse, licensed Employee E4 conducted on March 14, 2025, at 11:00 a.m., revealed that she/he does wound rounds with the wound doctor weekly. Employee E4 reported that the primary physician automatically agrees with the wound physician's recommendations and therefore does not need to be notified of changes in treatment orders. Employee E4 also reported that the nurse who did the wound rounds is responsible for reviewing the wound physician's report and putting in the orders in the EMR and transcribing it. A review of the February 2025, Treatment Administration Record (TAR) revealed that from February 4, 2025, until February 10, 2025, Resident 25's sacral wound was only treated with NSS, and Medihoney (A dressing that aids and support debridement and a moist wound healing environment in acute and chronic wounds and burns), and was covered with Optifoam. Calcium Alginate was not applied to the resident's sacral wound as recommended by the wound physician. A review of the physician's order dated February 3, 2025, revealed an order to cleanse the sacral wound with normal saline solution apply Meihoney, and cover with Optifoam daily and as needed. An interview with the Director of Nursing (DON) conducted on March 14, 2025, at 11:00 a.m., revealed that the wound nurse was not working on the day of the wound rounds. The nurse on duty was the one who placed the order into the EMR and transcribed it. The DON confirmed that the nurse missed the Calcium Alginate order. The facility failed to ensure Resident 25's wound care order was followed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on review of facility documents, facility policy, clinical records, resident interview, and staff interviews, it was determined the facility failed to ensure one of eight residents reviewed was provided with adequate supervision to prevent accidents for one resident (Resident 208) which resulted in actual harm when Resident 208 fell resulting in a fracture clavicle. Findings include: Review of facility policy titled Fall Management, review date of April 2023, revealed a fall is any event resulting in the resident coming to unintentionally on the floor or other lower level but not as a result of an overwhelming external force. Each resident will be assessed using a Holistic Assessment for potential risk for falls on admission, readmission and quarterly for continuing services. Therapy will complete an evaluation/screening on new admission and readmission and as needed for residents identified as fall risks. Care/service plans will be developed using individualized approaches identified during the assessment process. Review of facility policy titled Care/Service Plans, review date of May 2021, indicated each resident will have an individualized care/service plan developed. Care/service plans will include resident preferences, strengths, routines, personal and cultural preferences and choices as well as clinical needs. All interdisciplinary team members will document any updates/changes on care plan copy in the guest/resident suite/apartment/designated accessible location and review update with designated care associate. Review of Resident 208's admission record indicated resident was admitted to the facility on [DATE]. Review of Resident 208's admission record indicated diagnoses including but not limited to fracture of the lower end of left femur (hip fracture), iron deficiency Anemia (lack of iron), abnormalities of gait and mobility (abnormal walking pattern), muscle weakness and osteoarthritis left shoulder (break down of cartilage and joint tissue). Review of Resident 208's Admission Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated January 18, 2024, indicated diagnoses of hip fracture, renal insufficiency (poor functioning kidneys), Coronary Artery Disease (disease that effects main blood vessels that supply blood to the heart), and Hypertension (high blood pressure). Additional review of Resident 208's MDS assessment revealed the resident is dependent on staff for transfers indicating staff does all the effort, the resident does none of the effort to complete the activity, or the assistance of two or more staff is required for the resident to complete the activity. Further review of same MDS assessment revealed the resident requires substantial/maximum assistance with showers and bathing, staff does more than half the effort. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 208's clinical records revealed a progress note dated March 18, 2024, indicating During AM care resident had bruising to (his/her) left shin and reported pain in (his/her) left upper extremity, showing sign of limited range of motion. Upon assessment resident reported (he/she) was transferred with the assist on one staff member on Saturday, not assist of two as detailed in (his/her) plan of care. Resident reported a staff member fell on (his/her) during transfer, resident also reported falling a second time while in the shower room. Resident had left shoulder pain, stat x-ray ordered yielded left clavicle fracture. Review of facility incident report dated March 22, 2024, revealed a written witness statement dated March 18, 2024, from Nurse Assistant, Employee E3 who stated: I was washing (him/her) in the shower chair and (he/she) started to slide down and broke the arm to the shower chair as (he/she) slid. As (he/she) was sliding down, (he/she) was kind of leaning to (his/her) left side as (he/she) fell . I was trying to pull him/her back up, but he/she was heavy weight, so I pulled him/her a bit from behind and I pushed the button to open the door and called for Nursing Assistant Employee E6. Nursing Assistant Employee E6 stated we don't usually give (him/her) a shower, (resident) is a Hoyer (lift) (device designed to assist in safely transferring individuals with limited mobility), we give (him/her) a bed bath. I didn't know that. Review of information dated March 19, 2024, submitted by the facility on March 19, 2024 revealed, electronic version of resident's last assessment was reviewed. This identified the resident as a 2 person assist with use of a Hoyer lift. Upon further review of documentation it was identified the resident's plan of care paper copy detailed the resident's transfer status as assist of one person. Statements from additional employees detailed their routine use of two people assist to transfer resident with a Hoyer lift. Nursing Assistant Employee E3 went on to state that (he/she) did not use a Hoyer lift later in the day when caring for the resident (he/she) basically rolled the resident. Nursing Assistant Employee E3 confirmed telling the resident (he/she) would lift (him/her). Nursing Assistant Employee E3 stated usually I ask if I don t know (resident transfer status) but sometimes over there (on the unit) people don't help. Review of written witness statement dated March 19, 2024, from Nursing Assistant, Employee E4 indicated the following: Nursing Assistant Employee E3 called me to come in shower room. Resident was in a small gray shower chair with four legs. Resident was sliding out of it and Nursing Assistant Employee E3 asked me to help pull (him/her) up. I helped pull (him/her) up and called the nurse to come in the bathroom. The nurse came in and I went back to the dining room. Nursing Assistant Employee E4 further stated when providing care for Resident 208 she uses a Hoyer to transfer. Review of a written witness statement dated March 20, 2024, from Nursing Assistant Employee E5 stated: on Saturday I was in the M2 dining room assisting with breakfast when I saw Nursing Assistant Employee E3. He/she walked into our clean storage closet and got a sling. As Nursing Assistant Employee E3 was walking back Nursing Assistant Employee E3 said (employee) need me stating, 'can you help me? I need you to save my life, I need you badly.' I went to help Nursing Assistant Employee E3. The resident was sitting on the bench. I asked the resident is (he/she) could stand or hold anything, the resident said no. I asked Nursing Assistant Employee E3 how does the resident transfer? Nursing Assistant Employee E3 stated by Hoyer. I helped put the sling around the resident and then used the Hoyer to transfer the resident back to (his/her) room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a written witness statement dated March 18, 2024, from Resident 208, authored by Registered Nurse Employee E6 revealed: I asked Resident 208 to explain how (he/she) got bruise to left lower extremity. Resident 208 replied, on Saturday, a Nursing Assistant came in and said I was going to get a shower, (he/she) went to transfer me manually, I told (him/her) I needed the machine, (employee) replied, I am strong enough to do it myself. (He/she) then picked me up to transfer me and fell on to top of me. (He/she) took me to the shower room and left me there. Interview conducted on March 13, 2025, at 11:56 a.m. with Physical Therapist (PT) Employee E7 revealed, Resident 208 required two person assist with Hoyer for transfers per the evaluation completed on Post Acute Care (PAC)/Care Plan review dated March 13, 2024. Review of Resident 208's clinical records revealed a consult report from a medical service organization dated March 18, 2024, documented findings of Resident 208's clavicle (collarbone) examination as an acute nondisplaced fracture of the middle third of the left clavicle (injury caused by direct impact to the shoulder). During an interview conducted on March 13, 2025, at 12:14 p.m. confirmed Resident 208 was a two person assist with Hoyer lift, contrary to paper copy of Resident 208's care plan, located at the nurse's station for staff review, which indicated care plan was not updated and documented Resident 208 as one person assist. Resident confirmed being transferred prior to shower by one person, falling in the shower, and fracturing (his/her) collarbone. The Director of Nursing confirmed, by not using the Hoyer lift the resident was improperly positioned on the shower chair resulting in him/her sliding off chair and causing the fracture to Resident 208's collarbone. The Director of Nursing further confirmed the facility failed to ensure Resident 208 was provided with adequate supervision to prevent accidents which resulted in actual harm of a fractured collarbone for Resident 208. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41765 Based on facility policy review, clinical records review, and staff interviews, it was determined that the facility failed to ensure appropriate monitoring of weight and food intake was done and that significant weight change was timely addressed for one of 16 residents reviewed (Resident 20). Findings include: A review of the facility policy titled Weight Management, version June 2021, revealed residents would have their weight obtained on admission, re-admission, and monthly or at a frequency determined by the interdisciplinary team or provided. Residents with a weight variance equal to or greater than five pounds of five percent will be reweighed within 24 hours and weight will be entered into an EMR (Electronic Medical Record). The medical provider and responsible party will be notified of any significant change. Clinical records review revealed Resident 20's diagnosis list includes Prostate Cancer, Parkinson's Disease (A disorder of the central nervous system that affects movement, often including tremors), and Dysphagia (Difficulty swallowing). A review of Resident 20's weights revealed a weight of 144 pounds on September 4, 2024. The same report revealed Resident 20's weight was not taken for October 2024. On November 4, 2024, the resident's monthly weight was 128.8 pounds a 15.2 pounds weight loss in two months (10.56%), a significant weight loss. Clinical records review revealed Resident 20's identified significant weight loss on November 4, 2024, was not rechecked until November 10, 2024, which revealed a weight of 127.5 pounds. The clinical records review failed to reveal that the physician was notified of Resident 20's significant weight loss identified on November 4, 2024. A review of Dietitian Employee E3's note dated November 16, 2024, at 11:56 a.m., revealed resident was seen for a significant change in status. The same note revealed resident's appetite varies, noted to be fair most times, continue with a liberalized diet to keep him/her eating better. The same note revealed resident was offered shakes in the afternoon. Clinical records review failed to reveal an order for a milkshake. There was no documented evidence that Resident 20 had been offered and/or consumed the milkshake mentioned by the Dietitian on her/his assessment notes on November 16, 2024. Clinical records review also failed to reveal that Resident 20's meal intake was regularly monitored. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Employee E3 was conducted on March 14, 2025, at 10:00 a.m. Employee E3 reported that nursing is responsible for taking resident's weights and weighs are done within 24 hours. Employee E3 was unable to provide an answer as to why re-weigh was not done until six days later. When asked how the resident's meal intake was monitored, Employee E3 responded that it was done by talking to the nurses and doing meal observations herself/himself. Employee E3 was unable to provide a clear explanation why the resident was evaluated (by the dietitian) six days after weigh was obtained and significant weight loss was confirmed. Employee E3 reported that no further recommendations were made for the identified significant weight loss because the resident was already on a health shake. Employee E3 further reported that the health shake does not need to be in the order (physician), the kitchen automatically sends it to the unit after a request was made by the dietitian/nursing. The dietitian confirmed that there was no documented evidence that Resident 20 was offered/received a health shake in the afternoon and how much was consumed. The dietitian confirmed that the only documentation she/he had was when the kitchen sent the health shake to the unit and that it was received by nursing. An interview with the Director of Nursing on March 14, 2025, at 11:00 a.m., confirmed that Resident 20's meal intake was not consistently monitored and that there was documentation on the resident's medical records that the physician was notified of Resident 20's significant weight loss. The facility failed to ensure Resident 20's weight and meal intake were appropriately monitored and significant weight loss was timely addressed and the physician was notified. 28 Pa. Code 201.29(j) Resident Rights 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services