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

June 30, 2025

[redacted]
MARIS GROVE INC
[redacted]

RE: MARIS GROVE
500 MARIS GROVE WAY
1ST AND 3RD FLOORS
GLEN MILLS, PA, 19342
LICENSE/COC#: 13466

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/20/2025 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**: *03/11/2026*

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: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *03/01/2025* **Issued By**: *Concord Township*

Type: *I-2* **Date**: *03/01/2025* **Issued By**: *Concord Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *05/20/2025*

Inspection Dates and Department Representative

05/20/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *50*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd Floor Memory Care* **Capacity**: *44* **Residents Served**: *43*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *50* **Have Physical Disability**: *0*

Inspections / Reviews

05/20/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/16/2025*

06/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/29/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/29/2025*

Inspections / Reviews *(continued)*

06/30/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/29/2025*

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted], at 9:36 AM, several resident records were unlocked, unattended, and accessible in the first floor nurse's station across from room [redacted]

Plan of Correction ***Accept [redacted] - 06/19/2025)***

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?

Upon discovery of the deficient practice the Personal Care Manager immediately secured the Nursing Station to protect the confidentiality of the information. Team members working on the day of survey were immediately educated about protecting confidential information.

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 Administrator identified that all residents residing on the first floor had the potential to be affected by the deficient practice. The Personal Care Home Manager or designee will in-service the Personal Care team on the first floor and nurses on securing areas where confidential information is stored. Target date of completion for in-service June 30, 2025.

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 Home installed a combination lock that automatically secures the Nursing Station door. The Personal Care Administrator or designee will audit the access and security of the Nursing Station on the First Floor weekly for one month during environmental rounds and monthly for two months, auditing from June 2025 through August 2025.

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?

The Personal Care Administrator or designee will report monthly on the compliance of the Nursing Station being secure through our facility Quality Assurance/Performance Improvement (QAPI) program for the next 3 months beginning in the July 2025 QAPI meeting through September 2025 QAPI meeting reporting on result for June 2025 through August 2025 audits.

17 Record Confidentiality (continued)

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented [redacted] - 06/30/2025)

82c - Locking Poisonous Materials

2. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Medline Remedy Essentials Cleanse Spray Cleaner, with a manufacture's label indicating "for external use only in case of eye contact, flush eyes with water. If irritation persists, contact your physician", was unlocked, unattended, and accessible to residents in the 3rd floor activity room bathroom. Not all the residents of the home, including residents of the 3rd floor memory care unit, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 06/19/2025)***

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 Manager immediately removed the poisonous materials found in the common area bathroom and discarded the item. The remaining common areas were immediately assessed for compliance with the poisonous materials regulation.

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 Administrator identified that all residents residing on the third floor had the potential to be affected by the deficient practice. The item was discarded, and the team working was immediately educated on the about the deficient practice and the requirement to secure all poisonous materials.

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 or designee will in service all caregivers working in Memory Care regarding the poisonous materials regulation. Target date of completion for in service is June 30, 2025. The Personal Care Administrator or designee will audit the bathroom and common areas for poisonous material compliance weekly for one month during environmental rounds and monthly for two months, auditing from June 2025 through August 2025.

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?

82c - Locking Poisonous Materials (continued)

The Personal Care Manager or designee will report monthly on the poisonous material compliance through our facility Quality Assurance/Performance Improvement (QAPI) program for the next 3 months beginning in the July 2025 QAPI meeting through September 2025 QAPI meeting reporting result for June 2025 through August 2025 audits.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented [redacted] - 06/30/2025)

88a - Surfaces

3. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [redacted], at 10:05 AM, the handle to the 3rd floor linen closet door was broken and could not be closed securely.

Plan of Correction ***Accept ([redacted] - 06/19/2025)***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

On 5/20/25 when the deficient practice of the linen door in need of repair was identified, the Personal Care Home immediately notified maintenance and deficient practice was completed on 5/20/25.

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 Administrator identified that all residents residing on the third floor had the potential to be affected by the deficient practice. The Maintenance Manager or designee will conduct weekly audits of the Memory Care Linen door for functionality weekly for 3 weeks and monthly for two months.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Maintenance Manager or designee will conduct weekly audits of the Memory Care Linen door for functionality weekly for 3 weeks and monthly for two months auditing from June 2025 through August 2025.

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?

The Maintenance Manager or designee will report monthly on the Environment rounds compliance through our

88a - Surfaces (continued)

facility Quality Assurance/Performance Improvement (QAPI) program for the next 3 months beginning in the July 2025 QAPI meeting through September 2025 QAPI meeting reporting result for June 2025 through August 2025 audits.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 06/30/2025)

141b1 - Annual Medical Evaluation

4. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

As of , resident most recent medical evaluation was completed on . The resident's previous medical evaluation was completed on

Plan of Correction ***Accept - 06/19/2025)***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Due to the deficient practice being identified on a 2024 DME, the Personal Care Home Administrator and Clinical leadership team met with and in-serviced the Medical Providers on 6/6/25 on the 2600 Regulations related to DME completion so that future DME's would be compliant.

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 Administrator and Clinical Team completed a 100% audit of all current DME's to identify any trends or concerns with current DME's. The findings were reviewed during the in-service with the Medical Providers to prevent future deficient practices.

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 and Clinical Team have requested that the completed DME's be received prior to end of the allowable timeframe so the DME's can be audited for accuracy of information and compliance with the 2600 Regulations related to DME completion. The Personal Care Administrator and Clinical Team will track a 10% sample of DME dates and compliance monthly for 3 months, auditing from June 2025 through August 2025 to ensure the upcoming Annual DME's are within the allowable.

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?

141b1 - Annual Medical Evaluation (continued)

The Wellness Manager or designee will report monthly on the DME compliance through our facility Quality Assurance/Performance Improvement (QAPI) program for the next 3 months beginning in the July 2025 QAPI meeting through September 2025 QAPI meeting reporting result for June 2025 through August 2025 audits.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 06/30/2025)

183b - Meds and Syringes Locked

5. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On at 9:36 AM, two bins of resident medications were unlocked, unattended, and accessible in the first floor nurse's station across from room .

Plan of Correction ***Accept - 06/19/2025)***

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?

Upon discovery of the deficit practice the Personal Care Manager immediately secured the Nursing Station and the medication storage area to protect access to the medications. Team members working on the day of survey on the first floor were immediately educated about securing areas where medications are stored.

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 Administrator identified that all residents residing on the first floor had the potential to be affected by the deficient practice. The Personal Care Administrator or designee will in-service caregivers on the first floor and nurses on securing areas where medication is stored. The target date of completion for in-service June 30, 2025.

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 Home installed a combination lock that automatically secures the door to the Nursing Station and obtained the necessary keys for team members that require access to the medication storage areas. The Personal Care Administrator or designee will audit the access and security of the nursing station and medication storage area weekly for one month during environmental rounds and monthly for two months, auditing from June 2025 through August 2025.

183b Meds and Syringes Locked (continued)

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?

The Personal Care Administrator or designee will report monthly on the Nursing Station and medication storage security compliance through our facility Quality Assurance/Performance Improvement (QAPI) program for the next 3 months beginning in the July 2025 QAPI meeting through September 2025 QAPI meeting reporting result for June 2025 through August 2025 audits.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented [redacted] 06/30/2025)

187d - Follow Prescriber's Orders

6. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] Administer [redacted] ML by mouth twice a day and [redacted] sublingually every 4 hours as needed. However, resident [redacted] was administered the [redacted] on [redacted] at 8:09 AM and 4:05 PM instead of the [redacted] as prescribed.

Plan of Correction ***Accept [redacted] - 06/19/2025)***

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?

Upon discovery of the deficit practice of an incorrect Controlled Substances Utilization Record and Narcotic Count the Nursing Supervisors for the 3 11 and 11 7 shifts immediately initiated an investigation into the discrepancy and corrected the controlled substances utilization record.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

At the time of the discovery of the deficient practice resident #2 was the only resident receiving liquid Ativan. As part of a process improvement project, the Personal Care Home implemented a system to organize the Controlled Utilization Records for PRN and straight orders medications.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

187d Follow Prescriber's Orders (continued)

The Memory Care Manager and designee will re educate the Memory Care Nurses and Certified Medication Administration Assistants on proper counting of narcotics at change of shift. The target date of completion for in service June 30, 2025. The staff member responsible for the deficient practice received education and performance counseling in accordance with the Erickson Policy on Narcotic Administration Documentation. The Wellness Manager or designee will conduct weekly audits on 10% of residents currently receiving controlled liquid Ativan for the next 3 weeks and then monthly for two months.

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?

The Wellness Manager or designee will report monthly on the Narcotic compliance audits through our facility Quality Assurance/Performance Improvement (QAPI) program for the next 3 months beginning in the July 2025 QAPI meeting through September 2025 QAPI meeting reporting results for June 2025 through August 2025 audits.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented [redacted] - 06/30/2025)