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

November 27, 2023

[redacted], GENERAL MANAGER
MG MEDIA SUBTENANT LLC
[redacted]

RE: TRUEWOOD BY MERRILL, GLEN RIDDLE
263 GLEN RIDDLE ROAD
MEDIA, PA, 19063
LICENSE/COC#: 14582

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/04/2023 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: *TRUEWOOD BY MERRILL, GLEN RIDDLE* **License #**: *14582* **License Expiration**: *02/08/2024*

Address: *263 GLEN RIDDLE ROAD, MEDIA, PA 19063*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MG MEDIA SUBTENANT LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/01/1996* **Issued By**: *COPA L&I*

Staffing Hours

Resident Support Staff: *11* **Total Daily Staff**: *134* **Waking Staff**: *101*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *10/04/2023*

Inspection Dates and Department Representative

10/04/2023 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *153* **Residents Served**: *94*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *41* **Residents Served**: *28*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *94*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *29*

Have Physical Disability: *1*

Inspections / Reviews

10/04/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/21/2023*

11/09/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/20/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/20/2023*

Inspections / Reviews *(continued)*

11/27/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2023*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], at [redacted] a staff member noticed resident #1 had a skin tear on his/her forehead. The resident was sent to an emergency room, where he/she was diagnosed with a traumatic head injury caused by a fall, as well as a fractured vertebra. The home did not report this incident to the department until [redacted] at [redacted]

On [redacted], at [redacted] a staff member found resident #2 lying on his/her closet floor, complaining of pain in the right arm. The resident was taken to the hospital and diagnosed with a broken arm. The home did not report this incident to the department until [redacted].

On [redacted], at [redacted], a staff member found resident #3 lying on the floor of his/her room. The resident had an abrasion on the forehead and complained of rib pain and shortness of breath. The resident was taken by ambulance to a hospital, where he/she was diagnosed with broken ribs and a punctured lung. The home did not report this incident to the department until [redacted].

On [redacted], a staff person found resident #4 lying on the floor near a kitchen with a bleeding cut on his/her face. The resident was taken to the hospital by ambulance and diagnosed with a broken right elbow and bleeding of the brain. The home did not report this incident to the department until [redacted].

Plan of Correction ***Directed ([redacted] - 11/09/2023)***

All nurses and med techs were retrained in 2600.16.c on October 11, 2023 by the Resident Care Director.

Our practice had been to notify the department within 24 hours of learning of any injury. The hospitals do not always provide us with this information in a timely manner. Effective immediately, the Resident Care Director, General Manager, or their designated representative will contact the hospital within 24 hours of any injury necessitating hospitalization to assess whether it qualifies as a reportable incident. If it is a confirmed reportable event, the Resident Care Director, General Manager, or their designated representative will immediately submit the Incident Report to BHS to ensure compliance with the 24-hour reporting mandate.

Directed Plan of Correction ([redacted] 11/9/23)

- *In addition to the above noted steps, please add that all staff will be trained on incident reporting within 24 hours to the Department by 11/19/23, by the Resident Care Director or General Manager.*
- *Documentation of the incident training will be maintained for the Departments review.*
- *The General Manager will discuss the importance of reporting incidents timely at the monthly staff meetings for the next 3 months.*

Directed Completion Date:

Implemented [redacted] - 11/27/2023)