Department of Human Services
Bureau of Human Service Licensing

January 21, 2022

[redacted]
HEATHER GLEN SENIOR LIVING LLC
[redacted]

RE: HEATHER GLEN SENIOR LIVING
415 BLUE BARN ROAD
ALLENTOWN, PA, 18104
LICENSE/COC#: 22682

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/20/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *HEATHER GLEN SENIOR LIVING* **License #:** *22682* **License Expiration:** *01/29/2022*

Address: *415 BLUE BARN ROAD, ALLENTOWN, PA 18104*

County: *LEHIGH* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** *6108414478* **Email:** [redacted]

Legal Entity

Name: *HEATHER GLEN SENIOR LIVING LLC*

Address: *5930 HAMILTON BOULEVARD, WESCOSVILLE, PA, 18106*

Phone: *6108414478* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/16/2017* **Issued By:** *Upper Macungie Twsp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *149* **Waking Staff:** *112*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *10/20/2021*

Inspection Dates and Department Representative

10/20/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served:** *98*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *N/A* **Capacity:** *48* **Residents Served:** *39*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *98*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *51*

Have Physical Disability: *3*

Inspections / Reviews

10/20/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/29/2021*

Inspection Dates and Department Representative *(continued)*

12/12/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/17/2021*

01/21/2022 - Document Submission

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

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident 1 was seen being turned around and pushed in the back by staff member A. This was done to keep the resident from walking down a common area hallway within the secured unit. Resident 1 was overheard asking for staff member A to stop pushing them. The incident was witnessed and reported by staff member B. Repeat Violation from 4/19/2021.

Plan of Correction ***Accept***

Resident 1 was seen being turned around and pushed in the back by Staff Member A, who was from an [redacted]. Staff member A that is employed by Heather Glen Senior immediately called Director of Wellness to report what [redacted] observed. Heather Glen Senior Living have been trained that they are mandated reporters of abuse from the April staff meeting held on abuse. Heather Glen employee did everything [redacted] was taught to do. Director of Wellness came into the facility and pulled [redacted] F member A off the floor. Director of Wellness confronted [redacted] MEMBER about what was reported, Director of Wellness counseled [redacted] MEMBER that all residents need to be treated with dignity and respect, pushing is not a form of dignity and respect. [redacted] member denied the entire situation. Director of Wellness sent [redacted] MEMBER home immediately, never returned back on the floor to finish the shift.
Director of Wellness notified Executive Director of what took place. Executive Director was in agreement to how Director of Wellness handled the situation. Executive Director immediately notified the [redacted] o inform them of what their employee had done. Executive Director stated, that employee was not welcomed to come back into the facility. [redacted] apologized and pulled [redacted] from returning to Heather Glen.

Update: *12/12/2021*

Please send/Attach proof of staff training. 12-12-2021 MM

Document Submission ***Implemented***

Please see attach staff training for staff member A who was from [redacted] and Staff Member B who is employed with Heather Glen Senior Living.