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

November 30, 2023

[redacted], OWNER
GLENMAURA SENIOR LIVING AT MONTAGE LLC
11 GLENMAURA NATIONAL BLVD
MOOSIC, PA, 18507

RE: GLENMAURA SENIOR LIVING
11 GLENMAURA NATIONAL BLVD
MOOSIC, PA, 18507
LICENSE/COC#: 22845

Dear Ms. Kristen Angelicola,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/14/2023 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *GLENMAURA SENIOR LIVING* **License #**: *22845* **License Expiration**: *12/06/2023*

Address: *11 GLENMAURA NATIONAL BLVD, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *GLENMAURA SENIOR LIVING AT MONTAGE LLC*

Address: *11 GLENMAURA NATIONAL BLVD, MOOSIC, PA, 18507*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/01/2019* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *11/14/2023*

Inspection Dates and Department Representative

11/14/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *79*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *24* **Residents Served**: *19*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *79*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *31*

Have Physical Disability: *0*

Inspections / Reviews

11/14/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/27/2023*

11/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/30/2023*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

Inspections / Reviews *(continued)*

11/30/2023 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *11/30/2023*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Through information received in a complaint it was determined that on [redacted] staff person A tightly grasped the hand of resident #1 when resident #1 was wandering and following staff person A around. The incident was witnessed by a family member of the resident and reported to staff on [redacted]. The incident was not reported to the area agency on aging as required.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

After interviewing all staff that worked on [redacted] no staff member recalls family reporting incident. Family member asked the staff in charge what the girls name was that was working in the memory care unit. The charge staff member told family member the name and asked if everything was okay, he said yes just was wondering her name. Moving forward any incident involving suspected abuse will be reported to AAA. All staff were educated on 11/20/23 by administrator on what criteria fit for reporting suspected abuse. Director of Wellness will discuss any suspected abuse incidents daily during shift reports starting 11/21/23 any incidents that fit criteria will be reported. Administrator to monitor for ongoing compliance. (See attached)

Licensee's Proposed Overall Completion Date: *11/21/2023*

Implemented [redacted] - 11/30/2023)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

Through information received in a complaint it was determined that on [redacted] staff person A tightly grasped the hand of resident #1 when resident #1 was wandering and following staff person A around. The incident was witnessed by a family member of the resident and reported to staff on [redacted]. Staff person A was not placed on suspension after the incident and was not supervised while providing care to residents. Staff person A continued to work from [redacted] through [redacted]

Plan of Correction ***Accept [redacted] - 11/30/2023)***

There was no reason to believe that Staff member A did anything inappropriate because family member did not report incident until 10/7/23. Staff member was terminated on 10/8/23 unrelated to the abuse allegation. Moving forward any allegation of abuse of a resident involving a staff member will be immediately addressed and staff member will be suspended pending investigation. Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *11/21/2023*

Implemented (JH - 11/30/2023)

16c - Written Incident Report

3. Requirements

16c Written Incident Report *(continued)*

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

Through information received in a complaint it was determined that on [redacted] staff person A tightly grasped the hand of resident #1 when resident #1 was wandering and following staff person A around. The incident was witnessed by a family member of the resident and reported to staff on [redacted] The incident was not reported to the department's regional office as required.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

After interviewing all staff that worked on [redacted] no staff recalls family member reporting incident. All staff were educated on 11/20/23 by administrator on incidents that require reporting. Going forward all internal incident reports will be discussed daily during shift report by Director of Wellness to see if they fit the criteria for reporting. (see attached) Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *11/21/2023*

Implemented ([redacted] - 11/30/2023)

42b Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1 resides in the home's secure dementia unit and has a tendency to wander during 3rd shift hours. On [redacted] resident #1 was following staff person A into resident rooms. Staff person A became agitated with resident #1. Resident #1's family member observed staff person A holding resident #1's fingers tightly and also observed resident #1 crying. Resident #1's family member intervened and staff person A told the family member to get resident #1 out of the secure dementia unit.

Plan of Correction ***Accept ([redacted] - 11/30/2023)***

We do not agree with this violation. After interviewing Staff person A [redacted] denied holding residents fingers tightly. [redacted] did admit that resident was wandering into other residents rooms and resident needed constant redirection. Family member of resident lives in the facility as IL resident, [redacted] often takes resident back to [redacted] room to sleep. Staff member A asked family member if [redacted] could take [redacted] back to [redacted] room since [redacted] was in and out of the memory care unit the entire night which is common practice for [redacted]. All staff were educated on 11/20/23 by administrator on OAPSA as well as resident rights to ensure all staff are able to identify resident abuse and report accordingly. (see attached) Administrator will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *11/21/2023*

Implemented ([redacted] - 11/30/2023)