pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SNH PENN TENANT LLC**
LEGAL ENTITY

To operate **GLEN MILLS SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **242 BALTIMORE PIKE, GLEN MILLS, PA 19342**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **100**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 22**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 23,** **2024** until **June 23,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **145111**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 23, 2024

[redacted]
Chief Operating Officer
IntegraCare Corporation
[redacted]

RE: Glen Mills Senior Living
242 Baltimore Pike
Glen Mills, Pennsylvania 19342
License #: 145111

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 23 and 24, 2024, June 5, 6, and 12, 2024, and September 12, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 145110 dated January 1, 2024 to January 1, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated January 1, 2024 to January 1, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 23, 2024 to June 23, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

[redacted]

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
185a	II	44	$5	$220	5 calendar days from mailing date of this letter
188b	II	44	$5	$220	5 calendar days from mailing date of this letter
252	III	44	$3	$132	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

[redacted]

Sincerely

[redacted]

Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted], Office of General Counsel
[redacted], Director, Human Services Licensing
[redacted], Regional Director, Human Services Licensing

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

Facility Information

Name: *GLEN MILLS SENIOR LIVING* **License #**: *14511* **License Expiration**: *01/01/2025*

Address: *242 BALTIMORE PIKE, GLEN MILLS, PA 19342*

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

Administrator

Name: [redacted]

Legal Entity

Name: *SNH PENN TENANT LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/20/2020* **Issued By**: *Commonwealth of PA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *59* **Waking Staff**: *44*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/24/2024*

Inspection Dates and Department Representative

04/23/2024 On Site: [redacted]
04/24/2024 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *22* **Residents Served**: *4*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *44*

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

Have Mobility Need: *15* **Have Physical Disability**: *28*

Inspections / Reviews

04/23/2024 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *05/18/2024*

05/28/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/22/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/02/2024*

06/04/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/02/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/02/2024*

11/26/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/30/2024*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Personal care homes are considered "public places" under the Clean Indoor Air Act (35 P.S. § 637.1 – 637.11) and thus are subject to those regulations as well. According to the act, personal care homes must post a sign at each entrance that states "Smoking Permitted in Designated Areas Only" or "No Smoking."

The home's home rules do indicate that smoking is permitted in designated areas, however, the entrance of the home lacks a "No Smoking" sign, and there is no indication that smoking is only permitted in designated areas.

Plan of Correction ***Accept [redacted] - 06/04/2024)***

Director of Maintenance has posted a no smoking sign in the front entrance as of 5/18/2024.

Executive Director has inspected both designated smoking areas which are located in the front and the back of the building and both signs are visible to the public.

As of June 2024, Maintenance team will check on the designated smoking areas monthly to make sure signs are still visible, and the space is free of any debris.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented ([redacted] - 11/15/2024)

24 - Personal Hygiene

2. Requirements

[redacted]

24 - Personal Hygiene (continued)

[redacted]

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 04/23/24 at 10:10 am, two signs were posted outside the apartment of resident #3. One sign indicated the resident's inability to use the call bell and the need for regular checks, while the other sign noted that the resident should be escorted to the dining room for each meal. According to staff interviews, the family of resident #1 placed these signs to inform the staff of resident #3's requirements.

Plan of Correction

Directed ([redacted] - 06/04/2024)

Executive Director will contact the family by 6/30/24 to discuss state guidelines to preserve the resident's dignity.

DON will revise the RASP by [redacted] to ensure [redacted] care plan is in accordance with [redacted] needs, and document in [redacted] care plan that the residents need to be escorted to all meals.

DON will speak to the resident and educate[redacted] on how to use the call bell by [redacted]

Executive Director will follow up on 6/12/24 with the resident.

Directed Plan of Correction:

In addition to the above plan, within 7 calendar days of the receipt of this plan of correction, the administrator or designee shall audit all resident rooms for the presence of a voice activated device in the residents room. Any room with a device shall have a sign posted within 24hrs of audit, indicating the use of the device in the room. An audit of posted signs shall continue monthly for 3 months. Within 14 calendar days of the receipt of the acceptable plan, the home the shall develop or revise their policy for the use of voice activated devices in resident rooms and provide a 30 day written notice to residents indicating the policy is in effect. Additionally, the policy shall be reviewed with all new admissions and a sign will be posted at residents apartment to indicate the use of the device if resident

42s - Privacy (continued)

chooses to use one. Staff of the home shall also be in-serviced within 5 days of the policy revision, on the use of the devices, the need for posted signs and who to notify if a sign is required at a residents apartment. Documentation of the audits, the revision of the policy, copy of the 30 day notice and any staff training shall be kept and made available for Department review.

The signs posted at resident 3's door shall be removed immediately and contact with residents family shall be made within 24 hours of the receipt of this POC. Staff of the home shall receive in-service training within 5 calendar days on respecting residents privacy as well as using the residents support plan to provide all required assistance. Beginning within 7 calendar days of the receipt of the acceptable plan, the administrator or designee shall interview a sample of 5 residents and will monitor staff while providing care to 5 residents per week for one month and then monthly there after for 3 months. The resident interviews and observations will consist of questions to assess staff to resident interactions, residents privacy is being maintained and that care needs are being met. Documentation of the staff training, any record audits, staff observations and resident interviews shall be kept and made available for Department review upon request.

Proposed Overall Completion Date: 06/12/2024

Directed Completion Date: *06/12/2024*

Implemented [redacted] - 11/15/2024)

65i - Training Record

5. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of staff member D training does not include the number of hours trained on the training transcript.

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Executive Director checked into the system 5-23-24 to look at the format of the training records to ensure the required documentation is stated.

The training records do include name, date, name of training, location, curriculum, date of enrollment & completion, and hours.

Attached is verification of our training format.

Licensee's Proposed Overall Completion Date: *06/01/2024*

Implemented [redacted] - 11/15/2024)

66b - Training Plan Content

6. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.

66b - Training Plan Content *(continued)*

3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include the name, position and duties of each direct care staff person , the dates, times and locations of the scheduled training for each staff person for the upcoming year.

Plan of Correction ***Accept (MS - 06/04/2024)***

Executive Director will speak to the ASD by 6/30/24 to review the content and format of the training plan to update and add the required information that is needed for state compliance.

ASD will update the training plan as needed and ensure the curriculum is accordance with the team members role so they can perform their tasks effectively. This will be done by 7/15/24.

The ASD will review the training plan on a quarterly basis beginning on 7/15/24 to make sure the plan is in accordance with both company and state regulations.

Licensee's Proposed Overall Completion Date: *07/15/2024*

Implemented (CE - 11/15/2024)

87 - Lighting

7. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On April 23, 2024, at 10:30 AM, the memory care emergency exit fire tower on the first floor south, does not have adequate lighting. The lights were inoperable at this time.

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Director of Maintenance replaced all the lighting bulbs on 4/29/24.

A walk though of the building was performed on 5/10/24 by the Maintenance team to ensure adequate lighting.

Maintenance team will do a monthly check starting June 2024 to ensure all lighting bulbs are in operational order.

Licensee's Proposed Overall Completion Date: *06/10/2024*

Implemented ([redacted] - 11/15/2024)

88a - Surfaces

8. 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 04/23/24 at 9am, upon entrance to home, ceiling is in disrepair above second set of doors to enter the home;

88a - Surfaces (continued)

ceiling tiles are not present and it appears that there has been a leaking issue.

Plan of Correction ***Directed ([redacted] - 06/04/2024)***

A contractor came in on 5-20-24 to put existing tiles in for temporary use until the new tiles have been ordered.

Director of Maintenance will put in an order for new tiles in June 2024.

Installation will be done by the contractors by 6-30-24.

Proposed Overall Completion Date: 06/30/2024

Directed Plan of Correction:
In addition to the above plan of correction, the administrator or designee shall complete an audit of all areas of the home to monitor for any required repairs or hazards to floors, walls, ceilings and other surfaces. Any area of non-compliance shall be documented and corrected within 30 calendar days of identification. Monthly audits shall continue for 6 months. Documentation of audits shall be kept and made available for Department review upon request.

Directed Completion Date: *06/30/2024*

Implemented ([redacted] - 11/15/2024)

101j7 - Lighting/Operable Lamp

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #4 and resident #5 do not have access to a source of light that can be turned on/off at bedside.

Repeat Violation Date: 8/23/23

Plan of Correction ***Directed ([redacted] - 06/04/2024)***

Maintenance team has placed a lamp in both rooms as of 4/25/24.

Maintenance team will do monthly room checks to make sure all equipment in the residents' rooms are operable by 6/30/24.

Proposed Overall Completion Date: 06/30/2024

Directed Completion Date: *06/30/2024*

Implemented [redacted] - 11/15/2024)

107d - Procedure Emergency Management Agency Submission

11. Requirements

2600.

107d - Procedure Emergency Management Agency Submission *(continued)*

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted and updated since April 20, 2022.

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Executive Director has reach out to Concord township on 5/30/24 and scheduled a meeting on 6/3/24 to discuss the emergency plans.

Executive Director and Mr. Fields will review current plan in place, and next steps will be discussed on what is needed to obtain a new one, and to submit a recent plan.

The new plan and submission of letter will be done by 6/30/24

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented ([redacted] 11/15/2024)

121a - Unobstructed Egress

12. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On April 23, 2024, at 10 a.m., a sign with a red octagon stop sign symbol and the words "stop, emergency exit only" was posted on the door of the north wing fire tower. The red stop sign is visible from afar which is regarded as an obstruction or deterrent to the egress from the home's first-floor exit.

Plan of Correction ***Directed ([redacted] - 06/04/2024)***

As of 4/24/25 the Director of Dining has since removed the signs from the door.

Executive Director discussed with Director of Dining on 4/27/24 that signs that interfere with egress can't be posted due to fire safety procedures.

Directed Plan of Correction:
In addition to the above plan, Within 7 calendar days of the receipt of the acceptable plan, the administrator or designee shall conduct an audit of all emergency exits to ensure that there are no obstructions or other "STOP" signs. Any areas of non-compliance shall be corrected immediately upon discovery. Additionally, staff of the home shall be in-serviced on prevention of obstructed egresses within 14 calendar days of the receipt of the acceptable plan. Monthly monitoring of all areas for obstructed egress shall continue for at least 6 months. Documentation of audit and trainings shall be kept and made available for Department review upon request.

Directed Completion Date: *05/30/2024*

Implemented (CE - 11/15/2024)

132c - Fire Drill Records

13. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on October 31, 2022, at 4:10pm, December 22, 2022, at 4:59pm, February 28, 2023, at 1:40pm, and December 26,2023, at 3:40pm, does not include the location, the number of residents in the home, and the amount of time to evacuate.

Repeat Violation Date: 9/28/22 et al.

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Maintenance Director and Executive director discussed and reviewed on 5-21-22 the fire drill logs.

The Executive Director and Maintenance has reviewed the current fire drill format which does have the required documentation needed to be in state compliance. A copy of the fire drill each month will be presented to the Executive Director upon completion. This will begin for the month of June and will continue until further notice to monitor progress.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented ([redacted] - 11/15/2024)

132g - Fire Drills Days/Times

14. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the last week of the month as evidenced by the following drills December 26, 2023, at 3:40pm, January 31,2024, at 4:50pm, February 27, 2024, at 4:12pm, and March 29, 2024, at 11:37pm..

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Executive Director spoken to the Maintenance Director on 5/23/24 about the times and days required to do the monthly fire drills.

Maintenance Director beginning in the month of June will implement different time frames each month to facilitate the fire drills.

Executive Director will receive a copy of each fire drill to monitor this issue starting in June.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented ([redacted] - 11/15/2024)

144c1 - Smoking Area Guidelines

15. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area does not have fireproof receptacles. The designated smoking area out front consists of a wooden bench, chair, and table. However, it lacks a receptacle for safe cigarette disposal, and there is no sign indicating that it is a designated smoking area. Despite signs at the main entrance urging, "Please do not throw your butts on the ground," no safe disposal receptacle is available for residents or visitors to use.

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Maintenance Director put a smoking receptacle in front of the building as of 4/25/24.

Maintenance team will check on the designated smoking area bi-weekly to make sure it is not damaged or any debris on the property beginning in June 2024.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented ([redacted] - 11/15/2024)

161d - Dietary Needs

16. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #4 is prescribed a mechanical soft diet. However, on [redacted] at [redacted] the resident was served a cheesesteak on a roll and tater tot potatoes.

Plan of Correction ***Directed [redacted] - 06/04/2024)***

Director of Dining will hold a meeting on the education on residents' diet with the dietary team by 6-30-2024.

Director of Dining and Director of Nursing will review diet needs/orders weekly during morning meeting by June 10,2024. Director of Nursing will update resident charts when needed.

Proposed Overall Completion Date: 06/30/2024

Directed Plan of Correction:
In addition to the above plan, within 7 calendar days of the receipt of the acceptable plan, the administrator or designee shall in-service all direct care, nursing and dietary staff on proper specialty diets and ensuring resident's diet's served match their current orders. Additionally, the administrator or designee shall observe meals served twice weekly beginning within 7 calendar days to ensure residents are being served the correct diets. Weekly audits shall

161d - Dietary Needs (continued)

continue for 1 month, the shall be done monthly for 6 months. Documentation of in-service training and meal observations shall be kept and made available for department review upon request.

Directed Completion Date: *06/30/2024*

Implemented (CE - 11/15/2024)

183d - Prescription Current

17. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], [redacted] prescribed for resident #3, was in the home's medication cart; however, the medication was discontinued on [redacted]

The following medication [redacted] belonging to resident #3 was in the medication cart with an expiration of [redacted].

The following medication [redacted] tab for fever and pain belonging to resident #4 was in the medication cart with an expiration of [redacted]

Repeat Violation Date: 9/28/22 et al.

Plan of Correction ***Directed ([redacted] - 06/04/2024)***

DON has been implemented a weekly med cart audit to be conducted by both nurses and/or med-techs starting by [redacted].

The weekly audits will include checking on prescriptions, medication dates/times. Audits will be documented, and a copy will be provided to Executive Director to monitor progress.

Director of Nursing will be conducting a meeting with the nursing team on medication and prescriptions by 6-30-24.

Directed Plan of Correction:
The weekly cart audits and staff in-service trainings shall begin within 10 business days of the receipt of the acceptable plan.

Directed Completion Date: *06/30/2024*

Not Implemented [redacted] - 11/15/2024)

185a - Implement Storage Procedures

18. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #3 is prescribed Acetaminophen 325mg tabs as needed. On 04/24/24 this medication was not available in the home.

Repeat Violation Date: 9/28/22 et al.

Plan of Correction ***Directed [redacted] - 06/04/2024)***

DON will educate the nursing staff to review all medications prior to shift, and to call in the pharmacy when medications are running low 7 days prior.

DON has implemented a weekly audit beginning by 6/30/24 for a medication review to make sure all medications are accessible on the med cart.

Audits will be documented, and a copy will be provided to Executive Director to monitor progress.

Director of Nursing will be conducting a meeting on medication review by 6/30/24.

Directed Plan of Correction:

The weekly cart audits and staff in-service trainings shall begin within 10 business days of the receipt of the acceptable plan.

Directed Completion Date: *06/30/2024*

Not Implemented ([redacted] - 11/15/2024)

187a - Medication Record

19. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Residents #3 is prescribed [redacted], However, the residents medication administration record for the for these

187a - Medication Record (continued)

medications does not specify the diagnosis or the purpose of the medication.
Resident #4 is prescribed [redacted] *medications. However, the residents medication administration record for the for these medications does not specify the diagnosis or the purpose of the medication.*

Plan of Correction ***Directed (- 06/04/2024)***

Nursing will contact the pharmacy by 6/30/24 to schedule a medication cart audit to ensure all medications have both the diagnosis and purpose of the medication. This will be scheduled on a quarterly basis for continuous monitoring.

DON will conduct a training with the nursing team on medication labels, and MARS by 6/30/24.

Directed Plan of Correction:

The staff in-service trainings shall begin within 10 business days of the receipt of the acceptable plan.

Proposed Overall Completion Date: 06/30/2024

Directed Completion Date: *06/30/2024*

Not Implemented - 11/15/2024)

187d - Follow Prescriber's Orders

20. Requirements

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

Description of Violation

Resident #3 is prescribed [redacted] *, take one tablet by mouth daily. However, resident #3 was administered* [redacted] *on April 1, 2024, through April 24, 2024 at 9am.*
Resident #3 is prescribed [redacted] *20mg. However, this medication was not administered to resident #3 on April 24, 2024, because the medication was not available in the home.*

Repeat Violation Date: 12/21/23 et al.,

Plan of Correction ***Directed (- 06/04/2024)***

DON has addressed the medication error with staff on 4/24/24. Educated the team on importance of medication compliance and delivery.

The medication cart audits that will begin by 6-30-24 will help monitor the matter continuously to ensure we are in compliance.

DON will be conducting a medication training by 6-30-24 for the nursing team.

Directed Plan of Correction:
The weekly cart audits and staff in-service trainings shall begin within 10 business days of the receipt of the acceptable plan.

187d - Follow Prescriber's Orders *(continued)*

Directed Completion Date: *06/30/2024*

Not Implemented (- 11/15/2024)

224a - Preadmission Screen Form

21. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening form, dated does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident #4's preadmission screening form, dated does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept - 06/04/2024)***

The Marketing Director will do a thorough check on all pre-screening documents prior to admission beginning in June.

DON will check all documents prior to admission, and to review all of the information is updated and current.

A brief meeting will be conducted between the DON and Marketing Director at morning meeting beginning by 6-30-24 to discuss all forms and documentation that is needed for all admissions.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 11/15/2024)

227d - Support Plan Medical/Dental

22. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #1, dated , shows that the resident requires some physical assistance with dressing. According to the interview with resident #1, the home provides assistance. However, the support plan for resident #1, also dated , does not specify how this need will be addressed.

Resident #1's medical evaluation from , indicates that Resident #1 requires a . Resident #1's assessment and support plan dated , does not mention the resident's need for a .

Resident #4's medical evaluation from , indicates that Resident #4 requires a

227d - Support Plan Medical/Dental (continued)

[redacted].. Resident #4's support plan from [redacted], does not mention the resident's need for a [redacted]

Repeat Violation Date: 11/21/23

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

DON will conduct a chart review/audit on all resident files and update the information as needed. This audit will be completed by 6/30/24.

These audits will continue to be done on a quarterly basis beginning 6-30-24 to enhance the quality of care for the residents in accordance with their care plan.

Director of Dining will be sending the DON the weekly diet report to keep all files updated with the correct information. This will begin by 6/30/24.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] - 11/15/2024)

233c - Key-Locking Devices

23. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism was not posted for exiting the SDCU.

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Access codes have been posted for both the entering and exit doors in the SDCU on 5/20/24.

233c Key Locking Devices (continued)

Director of Maintenance can monitor this matter while performing the building tasks weekly by 6/30/24 to ensure all doors have access codes posted.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented ([redacted] - 11/15/2024)

252 - Record Content

24. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident#3's record does not include a photograph of the resident that is no more than 2 years old.

Resident#6's record does not include a photograph of the resident that is no more than 2 years old.

Repeat Violation Date: 9/28/22 et al.

Plan of Correction ***Accept ([redacted] - 06/04/2024)***

Marketing Director will take all photographs during the admission process starting on 6/30/24 and will continue with every new admission.

DON will update all of the residents' photographs by 6/30/24 in the EMR system.

DON will be monitoring this task while performing the quarterly chart review/audit on 6/30/24 and will continue to monitor.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] - 11/15/2024)

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

Facility Information

Name: *GLEN MILLS SENIOR LIVING* **License #**: *14511* **License Expiration**: *01/01/2025*

Address: *242 BALTIMORE PIKE, GLEN MILLS, PA 19342*

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

Administrator

Name: [redacted]

Legal Entity

Name: *SNH PENN TENANT LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/20/2020* **Issued By**: *COPA*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *91* **Waking Staff**: *68*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/12/2024*

Inspection Dates and Department Representative

06/05/2024 On Site: [redacted]
06/06/2024 On Site: [redacted]
06/12/2024 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *50*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *22* **Residents Served**: *9*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *50*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *41*
Have Physical Disability: *1*

Inspections / Reviews

06/05/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/26/2024*

08/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/27/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/12/2024*

10/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/19/2024*

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

11/15/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *10/10/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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

Resident 1 is prescribed [redacted] ml to be given by mouth every 8 hours. This medication was not administered to Resident 1 on [redacted] The home did not submit an incident report to the department.

Repeat violation: 12/21/2023 et al, 9/28/24 et al.

Plan of Correction ***Directed ([redacted] - 08/29/2024)***

Immediate action- The DON has provided education for the nursing team in regard to incident reports and the proper procedures. Training agenda is attached for verification purposes.

The med tech, LPN, or person responsible will contact the DON after completing an incident report. The DON will then notify the department via a reportable incident report. POA, and PCP will be notified. A care note will be completed. Follow up and education will be provided to the team member.

DON will conduct a monthly audit for review of incident reports starting 8/23/2024.

Proposed Overall Completion Date: 08/23/2024

Directed POC:

Immediately: *The administrator or designee shall complete an incident report for the incident involving resident 1 and submit the reports to the BHSL Southeast Regional Office.*

Immediately: *The administrator or designee shall review all reportable incidents and conditions at least weekly to ensure all reportable incidents and conditions are reported to the Department in accordance with regulation 2600.16c.*

Within 10 days of receipt of the plan of correction: *All staff persons shall be educated on the home's policy and procedures for reportable incidents and conditions including the reporting requirements. Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *09/08/2024*

Not Implemented [redacted] - 11/15/2024)

17 Record Confidentiality

2. Requirements

17 - Record Confidentiality *(continued)*

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 6/12/2024, resident records were unlocked, unattended, and accessible in the Wellness Office.

Plan of Correction ***Directed ([redacted] - 08/29/2024)***

DON will counsel team members on the importance of resident records.

Maintenance Director will order a keypad lock for security purposes so the doors will be locked at all times. Installment will be done by 9/15/24.

Proposed Overall Completion Date: 09/15/2024

Directed POC:

Immediately: *A designated staff person shall check the home on each shift to ensure all resident records and documentation are maintained in a confidential manner in accordance with regulation 2600.17.*

Within 10 days of receipt of the plan of correction: *All staff persons shall be educated on the confidentially of resident records and the procedures for maintaining resident records in a secure location, including the home's specific policy and procedures to comply with regulation 2600.17. Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *09/08/2024*

Not Implemented ([redacted] - 11/15/2024)

23a - Activities of Daily Living Assistance

3. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated 4/15/2024, for resident 2 indicates the resident requires Total Physical Assistance with Bladder and Bowel Management. Call bell response by staff, on the following dates and times

23a - Activities of Daily Living Assistance (continued)

indicates the resident did not receive this assistance, as required, in a timely manner: 5/10 5:47pm, response time 21m50s; 5/11 4:31 pm, response time 56m29s; 5/15 9:09 pm, response time 26m17s; 6/3 10:47am, response time 21m54s; and 6/4 5:30am, response time 30m8s.

The assessment and support plan, dated 4/15/2024, for resident 3 indicates the resident requires Total Physical Assistance with Bladder Management and Some Physical Assistance with Bowel Management. Call bell response by staff, on the following dates and times, indicates the resident did not receive this assistance, as required, in a timely manner: 5/1 4:45 pm, response time 21m40s; 5/10 9:06 pm, response time 45m21s; 5/29 4:01 pm, response time 23m35s.

Plan of Correction ***Accept ([redacted] 08/29/2024)***

Immediate action with a meeting that was conducted by the DON and EOO which educated team members in regard to call bell wait time, it was explained that all call bells are to be answered in a timely manner and if unable to then to reach out to another team member for assistance. Both of the training agendas has been attached.

DON will monitor the call bell report daily starting 8/8/2023
and will follow up and educate and/or counsel each team member with any excessive call bell wait times.

Licensee's Proposed Overall Completion Date: *08/23/2024*

Implemented ([redacted] - 11/15/2024)

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

42b - Abuse

On [redacted], Staff Person A, the only staff person working on the Memory Care unit, was in the kitchen "washing [their] hands", when, at approximately [redacted], the staff person heard screaming and ran immediately to the television room and saw Resident 4 lying near the fireplace with blood around the resident's head. Staff person A was not certified in first aid. Staff Person A went to the Memory Care Wellness Office to look another for a staff person to help. There was no one else on the unit, and Staff Person A was unable to contact other home staff to request assistance, because the walkie talkie on the unit was "dead". During this time, Resident 5's visitor heard screaming and found Resident 4 lying on the floor of the Memory Care Television Room, bleeding "profusely from the head". Resident 5's visitor was not able to locate any staff in the immediate area, and yelled out "Hey, Hey" in an attempt to get someone's attention. Resident 5's visitor then heard Staff Person A say, "I know, I know" and watched Staff Person A walk quickly by and out of the Memory Care Unit "into the other side of the building, instead of coming over to where Resident 4 was laying." Staff Person A left the Memory Care unit to go into the Personal Care unit to get assistance during the emergency, leaving the residents in Memory Care unattended. Resident 5's visitor then "got up, rushed past the other residents into the kitchen area and got paper towels" and went back and put the paper towels against the back of Resident 4's head, and noticed a "deep gash". Shortly after, Staff Person B and other staff came into the unit. Staff Person B assessed Resident 4 and gathered medical supplies. Resident 5's visitor was still holding the paper towels to Resident 4's head and offered their cell phone to Staff Person B to call 9 1 1; Staff Person B did not have their phone or a walkie talkie with them. Resident 5's visitor, still holding Resident 4's head, called 9 1 1, providing information and requesting an ambulance.

Plan of Correction ***Accept ([redacted] - 08/29/2024)***

Team members in all departments will be taking the online training on abuse and neglect to be completed by 8/31/2024, the Administrative Services Director will monitor and track the trainings and provide a weekly update on the status of each department to all managers.

DON has counseled and educated the team member in reference to safety and communication when in an emergency. This incident has resulted in disciplinary action explaining the importance of checking all equipment required upon entering the shift. The form has been attached for verification purposes.

Team members have been instructed to check all equipment prior to shift, make sure the volume is at an appropriate setting and to communicate to team members in case of an emergency.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Not Implemented ([redacted] - 11/15/2024)

85b - Infestation

5. Requirements

85b - Infestation *(continued)*

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 6/12/24, Gnats were flying in the marketing office and the elevator.

Plan of Correction ***Accept ([redacted] - 08/29/2024)***

Maintenance Director had services done in June and July, invoices have been attached for verification purposes. In addition, they will be doing a weekly check on all areas in the building for ongoing compliance starting 8/23/24.

Services will continue to be rendered until there is no evidence of insect infestation in the community.

Licensee's Proposed Overall Completion Date: *08/23/2024*

Implemented (CE - 11/15/2024)

90b - Staff Communication

6. Requirements

2600.
90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

On 5/14/24, Staff Person A was unable to communicate with staff in other areas of the home, during an emergency situation, because the available walkie talkie was dead.

Plan of Correction ***Accept ([redacted] - 08/29/2024)***

DON has implemented a sign in/out book for all equipment being used to keep track of the devices. DON will monitor the book weekly starting 8/8/24. The walkie talkies will be used for effective communication at all times.

DON will provide an education/training on the importance of staff communication, checking equipment prior to shift by 8/31/24.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented [redacted] 11/15/2024)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 6's medical evaluation, dated [redacted], did not include medical information pertinent to diagnosis and treatment in case of an emergency, and, special health or dietary needs of the resident.

Resident 7's medical evaluation, dated 5/15/24, did not include medical information pertinent to diagnosis and treatment in case of an emergency, and medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Plan of Correction ***Directed [redacted] - 08/29/2024)***

DON has conducted a chart review for all residents on June 15, 2024, to ensure all information is updated and corrected. Chart audit will continue on a quarterly basis by DON which began in June 15,2024. The chart audit is attached for verification purposes and will be done quarterly.

Proposed Overall Completion Date: 08/30/2024

Directed POC:

In addition to the above-mention plan of correction:

Immediately: *Residents 6 and 7's medical evaluations shall be sent back to the physician for completion or the home shall have a new in-person medical evaluation completed for each resident. The administrator or designated staff person shall develop and implement a process and procedure to ensure all newly completed medical evaluation are accurate and complete. The procedure shall be documented in writing and kept for review.*

Directed Completion Date: *08/31/2024*

Implemented [redacted] - 11/15/2024)

183d - Prescription Current

8. Requirements

183d - Prescription Current *(continued)*

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], prescribed for resident 3, was in the home's medication cart; however, there is no current order for this medication.

On [redacted] unit caplets, [redacted] tablets, prescribed for resident 7, were found in the home's medication cart; however, these medications were discontinued on [redacted]. Also found on the cart for individual 7 were [redacted], [redacted] tablets and OTC [redacted] tablets, however, there are no current orders for these medications.

On [redacted], prescribed for resident 8, was in the home's medication cart; however, there is no current order for this medication. [redacted] unit tablets, prescribed for this resident were found on the cart, however, this medication was discontinued on [redacted]

Repeat Violation: 9/28/22 et al.

Plan of Correction ***Accept ([redacted] - 08/29/2024)***

Immediate action consists of the implementation of weekly medication cart audits which began on June 20, 2024. These audits will continue to be done on a weekly basis under the supervision of the DON and/or Nurse Supervisor.
These audits will be monitored weekly by DON and/or LPN supervisor.

All audits have been attached for verification purposes.

In addition, a training/ education was conducted on 7/3/24 in reference to medication and prescription, training has been attached. Basirat will continue to educate and counsel team members for future reference.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Not Implemented [redacted] - 11/15/2024)

187a - Medication Record

10. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 9 is prescribed [redacted] , [redacted] . However, resident 9's medication administration record does not indicate diagnosis or purpose for the medication, including pro re nata (PRN).

Plan of Correction ***Directed [redacted] - 08/29/2024)***

Medication cart audits have been implemented weekly beginning June 20,24 to ensure all medication is properly labeled with the diagnosis.

DON has been monitoring all medication chart audits weekly since June 20,24 and will continue to do so to ensure compliance. Education was provided to the nursing team in July in regard to medication records, agenda has been attached for verification purposes.

187a - Medication Record (continued)

A meeting has been scheduled for September 5, 2024 with the pharmacy Polaris with a consultant to address concerns with medications and will request a quarterly medication audit from the pharmacy to be conducted on a continued basis.

Proposed Overall Completion Date: 08/31/2024

Directed POC

In addition to the above-mention POC:

Immediately: *The medication administration record for resident 9 shall be updated to include the diagnosis or purpose for all medications.*

Directed Completion Date: *08/31/2024*

Not Implemented (- 11/15/2024)

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

Resident 1 is prescribed . However, l was not administered to Resident 1 on

Resident 7 is prescribed , one capsule by mouth twice daily for 10 days , and, , one tablet by mouth daily. However, these medications were not administered to resident 7 on through because the medications were not available in the home.

Resident 8 is prescribed tablet by mouth once daily. However, this medication was not administered to resident 8 on the medication was not available in the home.

Repeat violation: 12/21/2023 et al.

Plan of Correction ***Accept - 08/29/2024)***

A meeting has been scheduled for September 5, 2024, with the pharmacy Polaris with a consultant to address concerns as far as medication delivery and labeling.

187d - Follow Prescriber's Orders (continued)

Basirat has begun weekly medication audits on June 20, 2024, to ensure compliance and will monitor weekly. Education has been provided to the team in July.

Executive Director will have copies of audits and monitor to make sure these audits are being conducted.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Not Implemented [redacted] - 11/15/2024)

188b - Medication Error Reporting

12. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident 1 is prescribed [redacted] to be given by mouth every 8 hours. However, resident 1 was not administered [redacted]. The medication error was not reported to the resident, resident's designated person, and/or prescriber.

Repeat violation: 12/21/2023 et al.

Plan of Correction ***Directed ([redacted] - 08/29/2024)***

LPN and/or med-tech must notify the RWD of all medication errors to the DON. The person responsible will monitor the resident, obtain vitals. Notify the PCP and POA. In addition, documentation will be required with follow up notes. DON will alert the department of the error.

DON will monitor to make sure the process is completed and accurate in the event of an error.

Education is to be provided to the nursing team by 8/30/24.

Proposed Overall Completion Date: 08/30/2024

Directed POC:

Immediately: *The resident, resident's designated person and the prescriber shall be notified of the medication error. Documentation shall be kept.*

Within 3 days of the receipt of the plan of correction: *The administrator or designated staff person shall monitor medication administration at least twice per week and monitor all resident MARs at least weekly to ensure any medication errors are properly reported. Documentation of monitoring and audits shall be kept.*

188b - Medication Error Reporting *(continued)*

Directed Completion Date: *09/02/2024*

Not Implemented (11/15/2024)

202 - Prohibitions

13. Requirements

[redacted]

[redacted] *- 08/29/2024)*

[redacted]

202 - Prohibitions (continued)

[redacted]

224a - Preadmission Screen Form

14. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 9 was admitted to the home on [redacted]; however, the resident's preadmission screening form was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 08/29/2024)***

DON and Marketing Director will conduct brief meetings prior to admission to ensure all paperwork is complete and meets state regulations.

Chart audit has been conducted on 8/15/2024 with both Regional Nursing and DON.

Prescreens are completed by Marketing Director prior to admission, will be reviewed by charge nurse and audited right away by DON within 24 hours of move in.

DON has been educated/trained on 8/15/2024 on the correct procedures for pre-admission screening, by Regional Nursing team.

224a - Preadmission Screen Form (continued)

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 11/15/2024)

225c - Additional Assessment

15. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 4's most recent assessment, completed on [redacted], indicates for Ambulating : independent and performs task safely, with or without assistive device. However, progress notes and/or incident reports indicate resident 4 has had several falls and injuries since this assessment, and the resident's RASP has not been updated to reflect an increased service need for Ambulating.

Based on staff interviews on 6/12/24, residents 5, 6, 7 and 10 have a need for two-person assists. The residents' most recent assessments do not document this service need.

Plan of Correction ***Accept ([redacted] 08/29/2024)***

Regional Nursing [redacted] facilitated a meeting/education on 8/15/24 for the DON in regard to assessments being updated and completed in a timely manner.

Executive Director will monitor chart audits beginning on 8/31/24. DON will conduct chart audits on a quarterly basis.

All residents who have a focus area of being a Fall Risk, RASPs will be reviewed and updated as needed. Moving forward any change or increase of assistance will be noted on Support Plan.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Not Implemented [redacted] - 11/15/2024)

227g -Support Plan Signatures

16. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 4 participated in the development of his/her support plan on 6/5/24. However, the resident nor home staff signed the support plan.

Resident 10 participated in the development of his/her support plan on 5/20/24. However, the resident did not sign

227g -Support Plan Signatures (continued)

the support plan. **Repeat Violation: 9/28/22 et al.**

Plan of Correction ***Accept (- 08/29/2024)***

All RASPS were audited for signatures from staff, resident and/or responsible party on 8/15/24. Moving forward RASPS will be signed as soon as completion and filed in the chart.

Chart audits has been done beginning June 15 ,2024 continue to be completed quarterly by the DON

Executive Director will monitor and audit all chart reviews to ensure this task is being completed.

DON has been educated on 8/15/2024 on the correct procedures for support plans.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Not Implemented - 11/15/2024)

234a - Admission Support Plan

17. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 4 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was completed on

Plan of Correction ***Accept (- 08/29/2024)***

Chart audit has been completed by RWD. All admissions to SDCU, the DON will have a new prescreen completed within 72 hours.

Audit will continue to be done quarterly moving forward.

DON has been educated on 8/15/2024 on the correct procedures for support plans, training has been attached for verification purposes.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented - 11/15/2024)

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

Facility Information

Name: *GLEN MILLS SENIOR LIVING* **License #**: *14511* **License Expiration**: *01/01/2025*

Address: *242 BALTIMORE PIKE, GLEN MILLS, PA 19342*

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

Administrator

Name: [redacted]

Legal Entity

Name: *SNH PENN TENANT LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/20/2020* **Issued By**: *COPA*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *69* **Waking Staff**: *52*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *09/12/2024*

Inspection Dates and Department Representative

09/12/2024 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *22* **Residents Served**: *8*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *44*

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

Have Mobility Need: *25* **Have Physical Disability**: *1*

Inspections / Reviews

09/12/2024 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *10/11/2024*

Inspections / Reviews *(continued)*

10/16/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *10/13/2024*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *10/21/2024*

11/13/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *10/21/2024*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

11/15/2024 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *11/13/2024*
Reviewer: [redacted]
Follow Up Type: *Enforcement*

65i - Training Record

1. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff Plan of Correction Training does not include date, content, and/or length of training.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

All training records will be documented properly by the facilitator pertaining to title, date, and length beginning October 18, 2024.

Training logs are to be reviewed by the facilitator and copy to be given to the Executive Director and filed away for documentation purposes.

DON will audit all files quarterly beginning October 18,2024 to ensure trainings are in compliance.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented [redacted] - 11/14/2024)

183d - Prescription Current

2. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] relieving patch prescribed for resident 1 was in the home's medication cart, however, there is no current order for this medication.

Repeat violation: 9/28/22 et al

Plan of Correction ***Accept [redacted] - 10/16/2024)***

Regional Nursing will educate/train lead med-tech on cart audits, on proper procedures and follow ups by October 31, 2024.

DON will oversee and complete all medication cart audits monthly beginning in the month of October and documentation is to be given to the Executive Director for verification purposes.

Regional Nursing will do a medication audit for the month of October and then quarterly.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented [redacted] - 11/14/2024)

183e Storing Medications

3. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 9/12/2024 an open bottle of Brimonidine Tartrate eye drops, prescribed to resident 1, was in the medication cart without an open date. According to the manufacturer's instructions these eye drops should be disposed of 4 weeks after opening.
On 9/12/2024 Latanoprost Sol .05% eye drops prescribed to resident 2, was in the medication cart without an open date. According to the manufacturer's instructions these eye drops should be disposed of 6 weeks after opening.

On 9/12/2024 Tramadol HCL Tab 50mg prescribed to resident 3, was punctured on the back of the bubble pack at spots 4,24,25 and 26. The tablets were present in the blister spot.

Plan of Correction ***Accept [redacted] - 10/23/2024)***

Regional Nursing will train lead-medication technician on proper techniques, procedures for OTC medications, and location of expired dates on medications, by October 31,2024.

Lead med-tech will then train/educate other medication aides on medication cart audits to ensure this process is done properly and team members are effectively trained on proper procedures for state compliance purposes, training to be done by October 31,2024.

Medication cart audits are done on a weekly basis , the DON will perform a follow up medication cart audit monthly and dispose of any medications that is required by October 15, 2024.

Regional nursing to perform a med cart audit beginning in October and will be facilitated on a quarterly basis.

Pharmacy has been contacted and will be scheduled to conduct a cart audit to ensure we are in compliance, by October 31,2024.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented ([redacted] - 11/14/2024)

184a - Resident's Meds Labeled

4. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

The pharmacy label on the bottle for resident 4's Lorazepam .5 mg tab does not include the prescribed dosage and instructions for administration.

Plan of Correction ***Accept [redacted] - 10/16/2024)***

Regional/Nursing to do a complete medication cart audit on all residents and medications labels by October 15 ,2024.

DON to follow up with any errors, and all revisions/corrections are to be made by October 31,2024.

DON to monitor this process on a monthly basis, documentation is to be done and given to Executive Director for verification purposes.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented [redacted] - 11/14/2024)

185a - Implement Storage Procedures

5. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident 5 is prescribed [redacted] daily as needed. On [redacted] this medication was not available in the home.

Resident 6 is prescribed [redacted] every 6 hours as needed. On [redacted] this medication was not available in the home.

Resident 7 is prescribed GG/DM Syp 100-10/5, three times a day as needed. On 9/12/2024, this medication was not available in the home.

Repeat violation: 9/28/22 et al

Plan of Correction ***Accept [redacted] - 10/16/2024)***

Education/training to be done by nursing staff on next steps for medication refills and orders by October 31,2024.
DON will monitor all medications and pull all physician orders and assure each medication on the physician orders is in the cart on a monthly basis starting in October and will continue until further notice.
DON to keep documentation and give it to the Executive Director for verification purposes.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented [redacted] - 11/14/2024)

252 - Record Content

7. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.

252 - Record Content *(continued)*

19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 8's record does not include a photograph of the resident that is no more than 2 years old.

Repeat Violation: 9/28/22 et al.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

On day one of admission the DON or designee will take a picture of the resident and upload it in Move-in and QMAR on day one of admission.

A chart audit will be conducted by nursing on a quarterly basis starting in October to ensure all charts are in state compliance, these audits to be done by October 31,2024.
DON will give documentation to the Executive Director after each quarterly chart audit for verification purposes.

The day of admission DON or designee will take a picture of the resident for their chart. Secondly the DON or designee will then upload it into our Move-in and QMAR on the day of admission.

A chart audit will be conducted by nursing on a quarterly basis starting in October to ensure all charts are in state compliance, these audits to be done by October 31,2024. DON will give documentation to the Executive Director after each quarterly chart audit.

Licensee's Proposed Overall Completion Date: *10/31/2024*

Not Implemented ([redacted] - 11/14/2024)