pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
March 14, 2025

[redacted]
Administrator
SNH Penn Tenant, LLC
[redacted]

RE: Glen Mills Senior Living
242 Baltimore Pike
Glen Mills, Pennsylvania 19342
License #: 14511

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on February 26, 2025 and March 14, 2025 of the above facility, we have determined that your submitted plan of correction for the January 3 and 14, 2025 inspection is not implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *GLEN MILLS SENIOR LIVING* **License #**: *14511* **License Expiration**: *06/23/2025*

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

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

Administrator

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

Legal Entity

Name: *SNH PENN TENANT LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/29/2000* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *70* **Waking Staff**: *53*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *01/03/2025*

Inspection Dates and Department Representative

01/03/2025 - On-Site: [redacted]

01/14/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *43*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *22* **Residents Served**: *5*

Hospice

Current Residents: *10*

Number of Residents Who:

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

Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *27* **Have Physical Disability**: *27*

Inspections / Reviews

01/03/2025 - Partial

Lead Inspector: [redacted]*g* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/02/2025*

02/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/27/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/08/2025*

02/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/27/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/28/2025*

03/14/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/27/2025*

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

23a - Activities of Daily Living Assistance

1. 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 [redacted] indicates that resident #1 requires a Hoyer lift and three-person assist to transfer in and out of bed or chair. On 12/23/24 at 9:07 pm, the resident was transferred from their chair to the bed by one staff person using the Hoyer lift.

Plan of Correction ***Do Not Accept ([redacted] - 02/03/2025)***

DON conducted training on resident care and ADLs on January 22,2025 with all ancillary team members.

DON also provided a separate training with nursing personnel on January 29,2025, resident care support plans and ADLs in specific to transfers and Hoyer lifts with two persons assist.

Memory care director will oversee transfers with resident # 1 to ensure the safety of the resident beginning February 3, 2025 for the next 30 days.

Team members will be counseled if not following the care plan moving forward.

Licensee's Proposed Overall Completion Date: *02/28/2025*

Update: *02/03/2025*

What immediate action was taken in response to this violation?

Ancillary staff provide services for residents other than ADLs. Are ancillary staff in your home also qualified to provide direct care?

What are the steps being taken to ensure compliance for every resident who requires assistance from more than 1 person to transfer?

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

DON conducted training on resident care and ADLs on January 22,2025 with all ancillary team members.

DON also provided a separate training with nursing personnel on January 29,2025, resident care support plans and ADLs in specific to transfers and Hoyer lifts with two persons assist.

Memory care director will oversee transfers with resident # 1 to ensure the safety of the resident beginning February 3, 2025 for the next 30 days.

Team members will be counseled if not following the care plan moving forward.

New submission
Violation of 2600.23.a

23a - Activities of Daily Living Assistance (continued)

Violation Description

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

Details: The assessment and support plan, dated 12/12/2024, indicates that resident #1 requires a Hoyer lift and three-person assist to transfer in and out of bed or chair. On 12/23/24 at 9:07 pm, the resident was transferred from their chair to the bed by one staff person using the Hoyer lift.

Short Term Actions

1. Immediate Intervention

1.1 Goals: Ensure that all residents receive assistance as indicated in their assessment and support plan.

1.2 Steps:

Conduct an immediate review of the current resident assessment and support plan for this resident to ensure accuracy.

Make any updates necessary for this resident.

1.3 Responsible Party: Resident Wellness Director

1.4 Time line: 2/24/2025

2. Immediate staff re-education

2.1 Goals: Educate all staff members on ADL support protocols and the importance of adherence to individual resident plans.

2.2 Steps:

Organize a training session for caregiving staff focused on the use of Hoyer lifts and the required 2 person (minimum) that comes with use of any mechanical lift.

New team members will be trained during onboarding.

Documentation of training will be maintained.

2.3 Responsible Party: Resident Wellness Director

2.4 Time line:

23a - Activities of Daily Living Assistance (continued)

Long Term Actions

1. Regular audits and monitoring

1.1 Goals: Ensure sustained compliance with resident assessment plans and ADL assistance needs.

1.2 Steps:

Implement a monthly review resident transfers and assistance needs.

Transfers and needs as well as updates/changes will be discussed in the monthly SQIRT (safety committee) meeting for 3 months.

Updates will be made to the support plan accordingly.

Documentation of SQIRT meeting minutes will be maintained.

1.3 Responsible Party: Resident Wellness Director/Safety Maintenance Engineer

1.4 Time line: To be implemented 2/17/25

Proposed Overall Completion Date: 02/17/2025

Licensee's Proposed Overall Completion Date: *02/17/2025*

Evidence of Completion ***Not Implemented ([redacted] - 03/14/2025)***

See attached.

Update: *03/14/2025*

Support plan for resident #1 was not updated.

Audits sheets do not identify who was observed and any issues noted. Audits sheets were to be completed daily and there dates that do not have observations.

Staff schedule shows several shifts with only one staff person scheduled.

42b - Abuse

2. 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 #2 was admitted to the facility's Secure Dementia Care Unit (SDCU) on [redacted]. The resident's cognitive preadmission screening indicates the resident exhibits agitation and confusion and requires extensive supervision. On 11/7/24, resident #2 wandered into another resident's room and became physically aggressive with the staff person who attempted to redirect the resident. On 11/8/24, resident #2 became agitated and was physically aggressive with

42b - Abuse (continued)

a hospice nurse. On 11/12/2024 at approximately 10:10 pm, resident #2 pushed on one of the fire-safety doors of the SDCU until the locks released. The resident made it outside and was escorted back into the home several times. Resident #2 was reported by the home as having "escaped" at least once during this incident. On 11/24/24, resident #2 wandered into another resident's room and then violently lashed out at a staff person who directed resident #2 to leave the room. Resident #2 was given a new assessment on 12/12/2024 (a month after the first incident). The resident's degree of wandering was updated from "no problem" to a "severe problem," stating, "Takes maximum staff intervention to prevent elopement."

On the afternoon of 12/22/24, there was one direct care aide, staff person A, working in the SDCU. Resident #2 left the unit, followed by [redacted] who was visiting, and attempted to leave the building through the front entrance. Staff person B was called from personal care to help coax the resident back to their room. Staff person A directed resident #2 to lay in their bed and then left to assist the four other memory-care residents, including resident #1, who requires three-person assistance.

Told that resident #2 had been put to bed, the resident's [redacted] hurried to check on resident #2, fearing the resident would again elope. Door alarms began sounding. The resident was discovered missing from their room at approximately 7:35 pm. Staff person C was called from home to assist in the search, which involved police and the resident's [redacted] in addition to staff. The search concluded after approximately 43 minutes, when staff person C found resident #2 behind the home's dumpster at 8:18 pm. The resident had eloped from the home from one of two exits near the resident's bedroom, by pressing on the doors from the SDCU to the stairwell and from the stairwell to the building's exterior for 15 seconds each until they released. The resident traveled about 100 yards in the cold without a coat.

Plan of Correction ***Do Not Accept ([redacted] - 02/03/2025)***

DON provided training with all team members on elopement procedures, proper response techniques, de-escalation strategies, identifying elopement factors, and abuse and neglect on January 22, 2025.

Maintenance Director to perform an elopement drill in the month of January. In addition, [redacted] installed extra set of alarms on the exit doors for safety precautions.

Memory care director will begin hourly checks on all residents beginning February 3, 2025 for the next 60 days.

Licensee's Proposed Overall Completion Date: *02/28/2025*

Update: *02/03/2025*

This plan of correction was submitted on 1/31/25. Did an elopement drill occur? if so, what were the results?

What immediate action was taken in response to this violation?

Resident 2 was on hourly checks at the time of the elopement. What additional steps are being taken to prevent another incident?

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

DON provided training with all team members on elopement procedures, proper response techniques, de-escalation strategies, identifying elopement factors, and abuse and neglect on January 22, 2025.

42b - Abuse (continued)

Maintenance Director to perform an elopement drill in the month of January. In addition, [redacted] installed extra set of alarms on the exit doors for safety precautions.

Memory care director will begin hourly checks on all residents beginning February 3, 2025 for the next 60 days.

New Submission

Violation of 2600.42.b

Violation Description

Code Definition: A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Details: Resident #2 was admitted to the facility's Secure Dementia Care Unit (SDCU) on [redacted] The resident's cognitive preadmission screening indicates the resident exhibits agitation and confusion and requires extensive supervision. On 11/7/24, resident #2 wandered into another resident's room and became physically aggressive with the staff person who attempted to redirect the resident. On 11/8/24, resident #2 became agitated and was physically aggressive with a hospice nurse. On 11/12/2024 at approximately 10:10 pm, resident #2 pushed on one of the fire-safety doors of the SDCU until the locks released. The resident made it outside and was escorted back into the home several times. Resident #2 was reported by the home as having "escaped" at least once during this incident. On 11/24/24, resident #2 wandered into another resident's room and then violently lashed out at a staff person who directed resident #2 to leave the room. Resident #2 was given a new assessment on 12/12/2024 (a month after the first incident). The resident's degree of wandering was updated from "no problem" to a "severe problem," stating, "Takes maximum staff intervention to prevent elopement." On the afternoon of 12/22/24, there was one direct care aide, staff person A, working in the SDCU. Resident #2 left the unit, followed by their [redacted] who was visiting, and attempted to leave the building through the front entrance. Staff person B was called from personal care to help coax the resident back to their room. Staff person A directed resident #2 to lay in their bed and then left to assist the four other memory-care residents, including resident #1, who requires three-person assistance. Told that resident #2 had been put to bed, the resident's [redacted] hurried to check on resident #2, fearing the resident would again elope. Door alarms began sounding. The resident was discovered missing from their room at approximately 7:35 pm. Staff person C was called from home to assist in the search, which involved police and the resident's spouse in addition to staff. The search concluded after approximately 43 minutes, when staff person C found resident #2 behind the home's dumpster at 8:18 pm. The resident had eloped from the home from one of two exits near the resident's bedroom, by pressing on the doors from the SDCU to the stairwell and from the stairwell to the building's exterior for 15 seconds each until they released. The resident traveled about 100 yards in the cold without a coat.

Short Term Actions

1. Elopement Prevention

1.1 Goals: To immediately address the risk of resident #2's elopement and ensure resident safety.

1.2 Steps:

42b - Abuse (continued)

Ensure resident's support plan is up to date and reflects resident #2's elopement tendencies and triggers. Include possible interventions to prevent future elopement.

A post-elopement review will be conducted to find root cause and possible mitigation strategies for future.

1.3 Responsible Party: Resident Wellness Director/LifeStories Director

1.4 Time line: To be completed by 2/24/25

2. Staff Training on Agitation Management and Elopement Prevention

2.1 Goals: To equip staff with skills to de-escalate situations involving agitated residents effectively as well as mitigating elopement for those at high risk.

2.2 Steps:

Arrange a training that will include elopement mitigation, conflict resolution and de-escalation training for caregiving staff.

Include modules on recognizing signs of agitation and appropriate interventions.

Documentation of the training will be maintained.

2.3 Responsible Party: Resident Wellness Director/LifeStories Director

2.4 Time line: 2/24/2025

Long Term Actions

1. Regular Resident Reassessment

1.1 Goals: To ensure resident care plans are up to date and reflect current needs and risks.

1.2 Steps:

Behavioral changes, wandering risks, and cognitive decline will be discussed during SQIRT meeting for residents at high risk or with changes for 3 months.

Update support plans accordingly.

Maintain documentation of SQIRT Team minutes.

1.3 Responsible Party: Resident Wellness Director/Safety and Maintenance Engineer

42b - Abuse (continued)

1.4 Time line: To be implemented 2/17/24

Licensee's Proposed Overall Completion Date: *02/17/2025*

Evidence of Completion ***Not Implemented (- 03/14/2025)***

See attached.

Update: *03/14/2025*

The home is still understaffed in memory care.

The additional door alarm was not armed on the date of the POCV inspection.

Support plan has not been updated.

Hourly checks provide no detail about what the resident was observed doing, if redirection was needed, etc.

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment and support plan, dated , indicates that resident #1 requires three-person assistance with transferring. On 12/23/24 at 9:07 pm, the resident was transferred by one staff person.

Resident #2's assessment, dated stated the resident has a severe problem with wandering and "takes maximum staff intervention to prevent elopement." Resident #2 wandered into another resident's room on 11/24/24 and when redirected, resident #2 became physically aggressive with staff. On 12/22/24 at approximately 7:30 pm, resident #2 eloped from the home for approximately 48 minutes after a previous elopement attempt earlier in the day.

The Secure Dementia Care Unit (SDCU) is being staffed with one direct care person with the part-time presence of a med-tech who serves the entire home. There are 5 SDCU residents in the home.

Plan of Correction ***Do Not Accept (- 02/03/2025)***

DON provided training and education on resident care, support plans, abuse and neglect, and ADLs on transfers January 29, 2025.

DON provided training with all team members on elopement procedures, proper response techniques, de-escalation strategies, identifying elopement factors, and abuse and neglect on January 22 ,2025.

Maintenance Director to perform an elopement drill in the month of January. In addition, installed extra set of alarms on the exit doors for safety precautions.

60a - Staff/Support Plan (continued)

Memory care director will begin hourly checks on all residents beginning February 3, 2025, for the next 60 days.

Proposed Overall Completion Date: 02/28/2025

Licensee's Proposed Overall Completion Date: *02/28/2025*

Update: *02/03/2025*

What was the immediate action taken in response to this violation.

This plan of correction does not address the specific violation.

What steps are being taken to address staffing to meet the needs of the residents as specified in the support plan?

What actions/steps will be put into plan to maintain ongoing compliance?

Plan of Correction ***Directed ([redacted] - 02/26/2025)***

DON provided training and education on resident care, support plans, abuse and neglect, and ADLs on transfers January 29, 2025.

DON provided training with all team members on elopement procedures, proper response techniques, de-escalation strategies, identifying elopement factors, and abuse and neglect on January 22 ,2025.

Maintenance Director to perform an elopement drill in the month of January. In addition, he installed extra set of alarms on the exit doors for safety precautions.

Memory care director will begin hourly checks on all residents beginning February 3, 2025, for the next 60 days.

Proposed Overall Completion Date: 02/28/2025

New Submission

Violation of 2600.60.a

Violation Description

Code Definition: Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

60a - Staff/Support Plan (continued)

Details: Resident #1's assessment and support plan, dated [redacted], indicates that resident #1 requires three-person assistance with transferring. On 12/23/24 at 9:07 pm, the resident was transferred by one staff person. Resident #2's assessment, dated [redacted] stated the resident has a severe problem with wandering and "takes maximum staff intervention to prevent elopement." Resident #2 wandered into another resident's room on 11/24/24 and when redirected, resident #2 became physically aggressive with staff. On 12/22/24 at approximately 7:30 pm, resident #2 eloped from the home for approximately 48 minutes after a previous elopement attempt earlier in the day. The Secure Dementia Care Unit (SDCU) is being staffed with one direct care person with the part-time presence of a med-tech who serves the entire home. There are 5 SDCU residents in the home.

Short Term Actions

2. Immediate staff re-education

2.1 Goals: Educate all staff members on ADL support protocols and the importance of adherence to individual resident plans.

2.2 Steps:

Organize a training session for all caregiving staff focused on the use of Hoyer lifts and the required 2 person (minimum) that comes with use of any mechanical lift. Discuss recent violation due to a hoyer being used with a resident and only one person performing the lift.

Re-educate on reaching out to other team members for help when needed to ensure the safety of the resident during transfers.

New team members will be trained during onboarding.

Documentation of training will be maintained.

2.3 Responsible Party: Resident Wellness Director

Long Term Actions

3. Quality Assurance and Monitoring

3.1 Goals: Establish robust mechanisms for ongoing quality assurance and adaptive improvements.

3.2 Steps:

Implement daily walking rounds by Resident Wellness Director and LifeStories Director to observe care and ensure that proper protocol is being followed to ensure the safety of the residents and team.

60a - Staff/Support Plan (continued)

Provide counseling when needed and disciplinary action when warranted for future violations of policy regarding mechanical lift transfers.

Documentation of rounds and any follow up actions will be maintained.

3.3 Responsible Party: Resident Wellness Director/LifeStories Director

3.4 Time line: Implemented 2/18/25

Proposed Overall Completion Date: 02/18/2025

Directed

Immediately: The administrator or designee shall review all resident assessments and support plans to determine the appropriate level of staffing needed to provide the appropriate care and services to each resident, including the appropriate level of staffing to evacuate all residents in the event of an emergency within the safe evacuation specified in writing by the home's fire safety expert. This person shall monitor the staffing schedule weekly to ensure the staffing levels are met to meet the resident's needs. Documentation of reviews shall be kept for review by the Department.

Directed Completion Date: *02/28/2025*

Evidence of Completion ***Not Implemented ([redacted] - 03/14/2025)***

See attached.

Update: *03/14/2025*

Support plan audits do not provide any details indicating updates made to support plans.

Staff schedule shows several shifts in memory care with only one staff person scheduled.

Nothing provided to show that residents have change and the number of staff schedule is sufficient to meet the need.

At the time of inspection, fire watch was being conducted by med techs on an hourly basis. This takes away from the time they have to provide direct care.

227g -Support Plan Signatures

4. 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 #1's support plan, dated [redacted], wasn't signed by any participants.

227g -Support Plan Signatures *(continued)*

Plan of Correction ***Accept (- 02/03/2025)***

Multiple copies were in the resident's file, the wrong assessment was given to the representative from the state.

DON and/or lead med-tech will conduct a chart audit by February 28,2025 to remove all old RASPS from resident's charts and make sure they are current.

A chart audit will be done quarterly moving forward until further notice.

Proposed Overall Completion Date: 02/28/2025

Licensee's Proposed Overall Completion Date: *02/28/2025*

Evidence of Completion ***Not Implemented (- 03/14/2025)***

See attached.

Update: *03/14/2025*

Audits do not indicate any errors found and corrected.

New violation cited at POCV inspection.