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

September 5, 2025

[redacted]
SNH PENN TENANT LLC
[redacted]
C/O INTEGRACARE CORP
[redacted]

RE: GLEN MILLS SENIOR LIVING
242 BALTIMORE PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14511

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/29/2025, 08/08/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *GLEN MILLS SENIOR LIVING* **License #**: *14511* **License Expiration**: *06/26/2026*

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: *I-2* **Date**: *03/19/2010* **Issued By**: *Concord Township, Delaware County, PA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *67* **Waking Staff**: *50*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *07/29/2025*

Inspection Dates and Department Representative

07/29/2025 - On-Site: [redacted]

08/08/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *46*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *22* **Residents Served**: *12*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*

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

Have Mobility Need: *21* **Have Physical Disability**: *1*

Inspections / Reviews

07/29/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/23/2025*

Inspections / Reviews *(continued)*

08/26/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/30/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/30/2025*

09/05/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/30/2025*

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

15a - Resident Abuse Report

1. Requirements

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

Description of Violation

On [redacted], at 6:40 PM, the home reported "suspected rough handling" of resident [redacted] by staff person A "sometime over the last few weeks (date unknown), due to some bruising on both arms". However, this allegation of abuse was not reported to the local area agency on aging.

Plan of Correction ***Accept ([redacted] - 08/25/2025)***

Immediate Reporting Procedure
Action Plan: Ensure immediate reporting and investigation of suspected abuse cases.
Steps:
Identify all incidents and allegations of abuse reported in the last month and check if they were reported.
Report the incident involving resident [redacted] to the local area agency on aging.
Review and verify documentation related to the incident.
Responsible Party: Executive Operations Officer
Timeline: Completed on 8.15.2025

Staff Training on Abuse Reporting
Action Plan: Improve staff awareness and response to abuse reporting protocols.
Steps:
Conduct a training session on the requirements of the Older Adult Protective Services Act.
Explain the importance of timely reporting to care staff
Responsible Party: Executive Operations Officer or Designee
Time line: Completed on 8.13.2025 & 8.14.2025

Long Term Actions?
Ongoing Monitoring?
Action Plan: Maintain high standards of awareness and education regarding abuse reporting.?

Monthly review of incidents to ensure that any allegations of abuse are reported immediately for 90 days

Responsible Party: Resident Wellness Director/Designee?
Timeline: To be implemented by 8/25/2025
?

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/05/2025)

25b - Contract Signatures

2. Requirements

2600.

25b Contract Signatures *(continued)*

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract, dated [redacted], for resident [redacted] was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 08/26/2025)***

Action Plan: Ensure all resident home contracts are fully executed as required by regulations.
Steps:
Identify and retrieve the incomplete contract for resident [redacted] immediately.
Obtain/attempt to get signature from resident
Responsible Party: Executive Operations Officer
Time line: Completed on 8.4.2025

Staff Training on obtaining signature/giving resident the option
Educate Marketing team (Community Relations Director) and Administrative Services Director on the regulatory requirements for contract execution to prevent future omissions.
Conduct a training session for the Administrative Service Director and Community Relations Director (Marketing team) on the contract signing process and legal requirements.
Responsible Party: Executive Operations Officer or Designee
Time line: Completed on 8.4.2025

Long Term Actions?
Ensure no other resident contracts are missing signatures or other required elements.
Perform an audit of all resident home contracts to identify any additional discrepancies.
Prepare a report of findings and make necessary adjustments.
Responsible Party: Administrative Services Director or Designee
Time line: Completed on 8.18.2025

Executive Director or designee will audit all new resident records to ensure paperwork is signed for 90 days.
Timeline: To be implemented by 8.25.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/05/2025)

41e - Signed Statement

3. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #[redacted] record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 08/26/2025)***

Action Plan: Ensure all resident home contracts are fully executed as required by regulations.
Steps:

41e - Signed Statement (continued)

Identify and retrieve the incomplete contract for resident [redacted] immediately.
Obtain/attempt to get signature from resident
Responsible Party: Executive Operations Officer
Time line: Completed on 8.4.2025
Staff Training on obtaining signature/giving resident the option
Educate Marketing team (Community Relations Director) and Administrative Services Director on the regulatory requirements for contract execution to prevent future omissions.
Conduct a training session for the Administrative Service Director and Community Relations Director (Marketing team) on the contract signing process and legal requirements.
Responsible Party: Executive Operations Officer or Designee
Time line: Completed on 8.4.2025
Long Term Actions?
Ensure no other resident contracts are missing signatures or other required elements.
Perform an audit of all resident-home contracts to identify any additional discrepancies.
Prepare a report of findings and make necessary adjustments.
Responsible Party: Administrative Services Director or Designee
Time line: Completed on 8.18.2025
Executive Director or designee will audit all new resident records to ensure paperwork is signed for 90 days.
Timeline: To be implemented by 8.25.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/05/2025)

60a - Staff/Support Plan

4. 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

The home typically has two Resident Wellness Associates scheduled for the 3:00 PM to 11:00 PM shift in the home's secured dementia care unit (SDCU); Life Stories. The management team of the home feels this is sufficient since there are 12 residents in the unit and additional staff are always available to help. However, staff interviewed stated they do not feel this is enough staffing to handle all the duties associated with this shift mainly because one resident requires assistance with feeding, there are two residents who require "2 person assist" with bathing and dressing (i.e.: getting ready for bed), and up to three residents who require the use of a Hoyer lift to get to bed. A Hoyer lift should be operated by a minimum of two people. Additionally, staff stated when they call over to personal care for assistance, sometimes they will get help but sometimes they just have to manage. Finally, staff stated there are at least two residents who need total care.

When staff person B, the Administrator/Executive Operations Officer, was informed of this violation, staff person B indicated that the incidents being investigated, plus two additional incidents, are the result of residents' "sundowning" or residents exhibiting dementia related behaviors. Additional staffing will help the home address resident behaviors during sundowning.

Repeat Violation: [redacted] et al.

60a - Staff/Support Plan *(continued)*

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Short Term Actions
Immediate Staffing Adjustment
Action Plan: Ensure adequate staffing for resident needs during the 3:00 PM to 11:00 PM shift in the SDU.
Steps:
Review current resident assessments and support plans to determine required staffing levels.
Temporarily adjust staffing by assigning an additional Wellness Associate for the affected shift until a permanent solution is implemented.
The staffing in the MC unit will be adjusted to have a third staff member present during anticipated care and transfers for the residents requiring a 2-person assist.
Communicate staffing adjustments to all relevant staff and ensure coverage is monitored daily.
Responsible Party: Resident Wellness Director or Designee
Timeline: Complete by 8/27/2025

Conduct Staff Meeting and Training
Action Plan: Gather staff input on workload and ensure they are well-prepared for duties during the 3:00 PM to 11:00 PM shift.
Steps:
Organize a staff meeting to discuss current challenges and gather feedback on staffing needs.
Provide targeted training on effective time management and resident care specific to the dementia care unit.
Implement an open feedback loop for ongoing staff concerns regarding shift coverage.
Responsible Party: Resident Wellness Director or Designee
Timeline: Complete by 8/27/2025

Long Term Actions
Implement Ongoing Staffing Audits
Action Plan: Continuously monitor staffing effectiveness and adjust as needed to meet resident care standards.
Steps:
Meet with the care staff biweekly to review the effectiveness of the staffing pattern and assignments.
Use audit results to make data-driven decisions about permanent staffing adjustments.
Responsible Party: Executive Operations Officer and Memory Care Director or Designee
Timeline: For 90 days

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented [redacted] - 09/05/2025)

65d - Initial Direct Care Training

5. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

65d - Initial Direct Care Training *(continued)*

3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   vi. Implementation of the initial assessment, annual assessment and support plan.
   vii. Nutrition, food handling and sanitation.
   viii. Recreation, socialization, community resources, social services and activities in the community.
   ix. Gerontology.
   x. Staff person supervision, if applicable.
   xi. Care and needs of residents with special emphasis on the residents being served in the home.
   xii. Safety management and hazard prevention.
   xiii. Universal precautions.
   xiv. The requirements of this chapter.
   xv. Infection control.
   xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted], began providing unsupervised ADL services in May 2024. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

The home mistakenly thought staff person A was a certified nursing assistant (CNA) but none of staff person A's information could be found on the CNA registry.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Direct care staff person A no longer works at the community.

Administrative Services Director completed an audit for all team members ensuring Direct care certificate is in the files on 8.15.2025
Executive Operations Officer completed Inservice with Administrative Services Director to ensure the importance of the Direct Care certificate prior to team member working on the floor.
Executive Operations Officer conducted a training session on the requirements of the successful completion of the direct care test and the certificate required prior to staff providing care in the community.
Timeline: Completed on 8.13.2025 & 8.14.2025

Long Term Actions?

Executive Operations Officer or designee will audit all new employee files to ensure DHS certificate is present for 90 days.
Timeline: Implementation date by 8.25.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/05/2025)

95 - Furniture and Equipment

6. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The switch to the lamp present in resident [redacted]'s room had a broken light switch and was not operational.

Plan of Correction ***Accept ([redacted] - 08/26/2025)***

Short Term Actions
Immediate Repair of Lamp
Action Plan: Ensure the resident's room is free from hazardous non-operational furniture and equipment.
Identify and replace the broken light switch on the lamp in resident [redacted] room immediately.
Ensure the replacement is operational and safe for use by the resident.
Responsible Party: Maintenance Supervisor
Timeline: Completed on 7.29.2025

Inspection of All Room Equipment
Action Plan: Verify that all equipment and furniture are safe and operational in all memory care resident rooms.
Conduct a thorough inspection of all memory care resident rooms to identify any similar issues or hazards with furniture and equipment.
Document any findings and arrange for immediate repairs or replacements if necessary.
Responsible Party: Maintenance Team or designee
Timeline: To be implemented by 8.25.2025

Long Term Actions?
Action Plan: Enhance staff ability to identify potential hazards early.
Inservice for memory care director and housekeeping team to ensure light source is available for all residents
Responsible Party: Executive Director
Timeline: Completed on 8.18.2025

Prevent future occurrences of faulty equipment.
The Maintenance Director or designee will audit all memory care rooms weekly for 90 days.
Maintenance Director or Designee
Timeline: To be implemented by 8.25.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented ([redacted] - 09/05/2025)

101j7 - Lighting/Operable Lamp

7. 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 [redacted] does not have access to a source of light that can be turned on/off at bedside. The switch to the lamp present in resident [redacted] room had a broken light switch and was not operational.

101j7 Lighting/Operable Lamp (continued)

Plan of Correction ***Accept (- 08/26/2025)***

Short Term Actions
Immediate Repair of Lamp
Action Plan: Ensure the resident's room is free from hazardous non operational furniture and equipment.
Identify and replace the broken light switch on the lamp in resident room immediately.
Ensure the replacement is operational and safe for use by the resident.
Responsible Party: Maintenance Supervisor
Timeline: Completed on 7.29.2025

Inspection of All Room Equipment
Action Plan: Verify that all equipment and furniture are safe and operational in all memory care resident rooms.
Conduct a thorough inspection of all memory care resident rooms to identify any similar issues or hazards with furniture and equipment.
Document any findings and arrange for immediate repairs or replacements if necessary.
Responsible Party: Maintenance Team or designee
Timeline: To be implemented by 8.25.2025

Long Term Actions?
Action Plan: Enhance staff ability to identify potential hazards early.
Inservice for memory care director and housekeeping team to ensure light source is available for all residents
Responsible Party: Executive Director
Timeline: Completed on 8.18.2025
Prevent future occurrences of faulty equipment.
The Maintenance Director or designee will audit all memory care rooms weekly for 90 days.
Maintenance Director or Designee
Timeline: To be implemented by 8.25.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented (09/05/2025)

191 - Resident Right to Refuse

8. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 08/26/2025)***

Action Plan: Ensure all resident home contracts are fully executed as required by regulations.
Steps:
Identify and retrieve the incomplete contract for resident #2 immediately.

191 - Resident Right to Refuse (continued)

Obtain/attempt to get signature from resident
Responsible Party: Executive Operations Officer
Time line: Completed on 8.4.2025
Staff Training on obtaining signature/giving resident the option
Educate Marketing team (Community Relations Director) and Administrative Services Director on the regulatory requirements for contract execution to prevent future omissions.
Conduct a training session for the Administrative Service Director and Community Relations Director (Marketing team) on the contract signing process and legal requirements.
Responsible Party: Executive Operations Officer or Designee
Time line: Completed on 8.4.2025
Long Term Actions?
Ensure no other resident contracts are missing signatures or other required elements.
Perform an audit of all resident-home contracts to identify any additional discrepancies.
Prepare a report of findings and make necessary adjustments.
Responsible Party: Administrative Services Director or Designee
Time line: Completed on 8.18.2025
Executive Director or designee will audit all new resident records to ensure paperwork is signed for 90 days.
Timeline: To be implemented by 8.25.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/05/2025)

227g -Support Plan Signatures

9. 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 [redacted]s support plan, dated [redacted], is not signed by the staff person who completed the plan.

Repeat Violation: [redacted] et al.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Short Term Actions
Verify Missing Signatures
Action Plan: Ensure all current support plans have the required signatures.
Steps:
Identify all support plans that need verification for missing signatures.
Contact responsible staff members to complete missing signatures.
Audit all support plans to ensure compliance with signature requirement.
Responsible Party: Resident Wellness Director or Designee
Timeline: Completed on 8.18.2025

Staff Training on Signature Protocol
Action Plan: Educate LPN staff on the importance and procedure of signing support plans.
Responsible Party: Executive Operations Officer

227g -Support Plan Signatures (continued)

Timeline: Completed on 8.18.2025

Long Term Actions
Implement Regular Audits
Action Plan: Regularly check support plan documentation for completeness.
Steps:
Establish a monthly audit schedule for reviewing support plans for 90 days
Assign responsibility for audits to a senior staff member.
Document findings and make them available for management review.
Responsible Party: Resident Wellness Director or Designee
Timeline: Completed on 8.18.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented ([redacted] - 09/05/2025)

233c - Key-Locking Devices

10. 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 magnetic locking mechanism on the level 1, stair 2 fire tower exit door are not conspicuously posted near the door.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Short Term Actions
Ensure Proper Posting of Directions
Action Plan: To promptly post clear directions for operating the magnetic locking mechanism at the level 1, stair 2 fire tower exit door to ensure safety compliance.
Design and print clear and easy-to-read directions for the operation of the magnetic locking mechanism.
Post these directions conspicuously near the level 1, stair 2 fire tower exit door.
Verify the visibility and readability of the directions from various angles upon approach.
Responsible Party: Maintenance Manager
Timeline: Completed on 7.29.2025
Conduct Staff Training
Action Plan: To ensure housekeeping team understand the process and importance of the proper operation of exit devices and the significance of posting instructions.
Responsible Party: Maintenance Director or Designee
Timeline: Completed on 8.18.2025

Long Term Actions
Regular Audits for Compliance
Action Plan: To routinely check all exits with key-locking or electronic card systems to ensure directions are posted conspicuously and in compliance with regulations.
Steps:

233c Key Locking Devices (continued)

Create a compliance audit schedule to routinely check all relevant exit points across the facility.
Conduct audits weekly for 90 days
Compile audit results and implement corrective actions immediately when non compliance is found.
Responsible Party: Maintenance Director or Designee
Timeline: Implemented on 8.18.2025

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] 09/05/2025)