

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

February 10, 2026

[REDACTED]
GLENCREST MANOR INC
[REDACTED]
[REDACTED]

RE: GLENCREST MANOR
115 GLENCREST ROAD
COATESVILLE, PA, 19320
LICENSE/COC#: 19780

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/13/2025 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: GLENCREST MANOR **License #:** 19780 **License Expiration:** 06/17/2026
Address: 115 GLENCREST ROAD, COATESVILLE, PA 19320
County: CHESTER **Region:** SOUTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: GLENCREST MANOR INC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: R 4 **Date:** 10/18/1996 **Issued By:** Valley Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 10 **Waking Staff:** 8

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Incident, Monitoring **Exit Conference Date:** 08/13/2025

Inspection Dates and Department Representative

08/13/2025 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity: 13	Residents Served: 9		
Secured Dementia Care Unit			
In Home: No	Area:	Capacity:	Residents Served:
Hospice			
Current Residents: 0			
Number of Residents Who:			
Receive Supplemental Security Income: 2	Are 60 Years of Age or Older: 2		
Diagnosed with Mental Illness: 9	Diagnosed with Intellectual Disability: 0		
Have Mobility Need: 1	Have Physical Disability: 0		

Inspections / Reviews

08/13/2025 - Partial
Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 09/19/2025

Inspections / Reviews *(continued)*

10/02/2025 POC Submission

Submitted By: [REDACTED] Date Submitted: 09/23/2025
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 10/06/2025

02/10/2026 POC Submission

Submitted By: [REDACTED] Date Submitted: 10/06/2025
Reviewer: [REDACTED] Follow Up Type: Bypass Document Submission

02/10/2026 Bypass Document Submission

Submitted By: [REDACTED] Date Submitted: 02/10/2026
Reviewer: [REDACTED] Follow Up Type: Not Required

42b - Abuse

1. 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

According resident's progress notes and interviews, resident's family member called the home on asking for staff to check on resident. The family member stated the resident asked not to be picked up because they were having intrusive thoughts about the family member. Staff person A checked on the resident and the resident stated, " was good." Staff person A stated that they made an appointment with the psychiatrist for . Staff person A did not check on the follow-up with the resident.

On resident left the home at 11:00 am without telling staff. On during the resident interview resident disclosed that left the home because was having thoughts of harming others but no one in specific. The resident stated that made a left outside of the home and walked until saw the woods on Lincoln Highway. The resident stated that phone died while in the woods. The resident stated that was alone in the woods and stayed there until the morning of , when decided to return to the home on own. On the resident was transported to Chester County Hospital by EMS after disclosing that was still having thoughts of harming others. On the agent of the Department spoke to resident's family member and they disclosed that Chester County Hospital reported that resident was dehydrated. Resident's family member disclosed that the resident was eating pies took from the home that were provided by the family, cigarettes and a cell phone.

On , resident had an unwitnessed fall. Resident slipped in the kitchen and was unable to get up independently. Resident crawled to ask other residents in the home for assistance because staff were not present. Resident stated that knocked on resident's bedroom. Resident searched inside and outside of the home for staff and could not locate any staff. Resident provided resident with the homes' phone to call 911. EMS assisted the resident with being transferred from the floor onto the resident's bed. EMS assessed resident for injury and concluded they did not need to be transported to the hospital. The resident stated that after EMS left the home staff person B knocked on bedroom door to ask what had happened and if was okay. On 8/13/2025, during the interview with resident disclosed that they had a bruise on their right foot on top of toes from the fall and had a bruise on their right knee. The resident did not go to the hospital following the incident. On 8/13/2025, resident disclosed to the agent of the Department that when resident fell in the kitchen and gave resident the home's phone to call 911 because the resident needed assistance. Staff person B was supposed to be at the home and was not.

Staff person B left the residents alone in the home from 10:50 pm to 11:40 pm to drive staff person C home. Both staff persons B and C were terminated.

Repeat Violation:

Plan of Correction

Accept - 10/01/2025)

Staff Persons B and C were terminated on due to abandonment of residents and failure to follow supervision protocols. All current staff must obtain or renew First Aid, CPR. Proof of certification will be maintained in each employee file. Scheduling policies have been updated to ensure at least one CPR/First Aid-certified staff is present at all times, including overnight and shift changes. A backup on-call system was implemented on August 20, 2025, ensuring no staff leaves the premises unless a certified replacement is on-site. The Administrator will continue to perform monthly audits of staffing schedules and certifications to ensure continued compliance. Designated staff

42b Abuse (continued)

will watch the homes cameras thru out each shift and overnight to ensure the home has a staff person in it at all times. All new hires will be informed that leaving the home will be immediate discharge of employment. I disagree with the statement that there was no follow up with the resident before elopement, that is not true. A written Mental Health Alert Protocol will be implemented by September 30, 2025, requiring: Immediate documentation of behavioral alerts. Clinical follow up within 24 48 hours. Notification of the physician and family. Risk assessment within 12 hours. Family of resident is considering a air tag on the resident's phone or subscribing to find my iPhone to ensure this never happens again. All residents are required to sign out on a already made sign out sheet, that will now be enforced for all shifts

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented [redacted] 02/10/2026)

63a - First Aid/CPR Training

2. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On [redacted], from 10:50 pm until 11:40 pm, 9 residents were present in the home. During this time zero staff persons were present in the home who were certified in first aid and CPR.

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] 10/01/2025)

The staff person that was scheduled to work and left the home was fired immediately after reviewing the situation. A certified staff member is to always be at the home at all times. The staff schedule was reviewed and revised to ensure all shifts were covered. All staff certifications were verified on 8/6/25. Administrator or designee will review schedule weekly to ensure compliance. At the time of a new hire the administrator will speak largely at the point that the residents can never be left alone and if there is ever of issue of another employee not showing up on time then the on call person needs to be called. An on call staff is always labeled on the schedule. The home will also strive to fine employees that are more responsible and understand the severity of leaving the home unattended

Licensee's Proposed Overall Completion Date: 09/18/2025

Implemented [redacted] - 02/10/2026)

65d - Initial Direct Care Training

3. 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.
3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs

65d Initial Direct Care Training (continued)

- 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 C, hired on [REDACTED] began providing unsupervised ADL services on [REDACTED]. However, the staff person did not complete and pass the Department approved direct care training course and pass the competency test until [REDACTED]

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/01/2025)

Staff person C started the test here at the home with the admin assistant when hired for the position, [REDACTED] then finished the test on [REDACTED] own time. [REDACTED] stated [REDACTED] got locked out of the system because of a password and not being able to log into the email [REDACTED] had signed up with. To make sure this does not happen again, all new employees will now take the test at Glencrest before starting their training for their position, they must print their certificate here at the home to avoid this happening again. Admin assistant will then keep checking the staff files and make off on the monthly checklist that is already being done to make sure all staff paperwork is complete and up to date

Licensee's Proposed Overall Completion Date: 09/18/2025

Implemented [REDACTED] - 02/10/2026)

101j2 - Bedroom Chairs

4. Requirements

- 2600.
- 101.j. Each resident shall have the following in the bedroom:
 - 2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedroom [REDACTED] is occupied by 3 residents; however, there is only one chair in this room.

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/02/2025)

2 chairs were placed in the room on day that the inspector was here, the home had just had a resident council meeting, and the chairs were used for all residents to be in the same area and accidentally taken downstairs instead of back in the room. The meeting was a few days prior to the inspection The home does perform room checks weekly

101j2 Bedroom Chairs (continued)

to ensure all appropriate items are in the room. The administrator did verbally speak to all the staff to review the checklist and what should be in the room on 8/15/25.

Licensee's Proposed Overall Completion Date: 09/18/2025

Implemented [redacted] - 02/10/2026)

101j7 - Lighting/Operable Lamp

5. 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.

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] - 10/02/2025)

Resident [redacted] had a switch plate light that sticks to the wall, but they were flipping them so hard it kept coming off the wall so i used gorilla tape and stuck it to [redacted] nightstand while the inspector was here. Resident [redacted] shares a lamp with [redacted] roommate it is on the nightstand between both beds, the lamp was pushed over a tad towards the other resident's side. we can't really avoid the lamp getting moved an inch when they turn it on, or with just daily movement in the room. Resident 3 stated [redacted] does not want the lamp in the middle because [redacted] would rather put [redacted] mail there. I also gave [redacted] a tap light on the wall and [redacted] keeps taking it down and putting it in [redacted] drawer. There is one large lamp in between both beds, if it gets moved an inch we will put it back in the middle. Checking lamps is also included on the weekly checklist

Licensee's Proposed Overall Completion Date: 09/18/2025

Implemented [redacted] - 02/10/2026)

102k - No Common Towel

6. Requirements

2600.

102.k. Use of a common towel is prohibited.

Description of Violation

There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in the shared [redacted] bathroom.

Plan of Correction

Accept [redacted] - 10/02/2025)

The administrator has decided to put a hand dryer in the men's bathroom. We do put disposable towels in there, but they will use over 500 towels in a couple days, and they put them down the toilet even though there is a sign in the bathroom asking them to dispose in the trash can. The residents that use that bathroom have hand towels in their

102k No Common Towel (continued)

room they were taking in with them. The hand dryer will be added to the bathroom by 11/1/25, until the dryer is installed the home will put paper towels in the dispenser, they will be checked when staff clean the bathroom for the day

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [redacted] - 02/10/2026)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

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 [redacted] medical evaluation dated [redacted] did not include the need for body positioning and movement stimulation for the resident.

Plan of Correction

Accept [redacted] - 10/02/2025)

The Med evaluation did not have a completed section. It was an oversight by the doctor and staff. The monthly chart checks are still being implemented to ensure all required sections are completed at the time of admission or annually. Admin assistant will review all incoming evaluations upon receipt for completeness before putting in the charts, any information that is missing will be immediately returned to the healthcare provider for completion. The administrator will audit 100% of the medical evaluations monthly, the audits are checked off on the checkoff sheet. Training for all required paperwork is done annually with all staff.

Licensee's Proposed Overall Completion Date: 09/18/2025

Implemented [redacted] - 02/10/2026)

201 - Positive Interventions

8. Requirements

2600.

201. Safe Management Techniques [redacted] home shall use positive interventions to modify or eliminate a behavior that endangers the resident [redacted] or others. Positive interventions include improving communications, reinforcing appropriate behavior, direction, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident [redacted] verbally stated that [redacted] wanted to physically harm people on [redacted] The resident was admitted to an inpatient facility for treatment. On [redacted], resident [redacted]'s family notified staff person A that the resident was

201 Positive Interventions (continued)

having instructive thoughts about this family member and asked that they check on the resident. On [REDACTED], staff person A spoke to resident [REDACTED] and [REDACTED] responded, that [REDACTED] was good. Staff did not continue check on resident [REDACTED]. On [REDACTED], the resident left the home and was in the woods near Lincoln highway for 3 days due to having thoughts of harming others but no one specifically. The home was aware that resident [REDACTED] had previously been hospitalized for having thoughts of harming others; however the home failed to act timely on the report from the family that resident [REDACTED] was having intrusive thoughts on [REDACTED]. The home made an appointment for resident [REDACTED] to see a psychiatrist on [REDACTED].

Plan of Correction

Accept [REDACTED] - 10/21/2025)

~~I disagree. The staff members did continue to check on Resident [REDACTED] after they spoke to family for days. That was never brought up during inspection and that is very false. The resident was very happy following that comment and was in the common area laughing and chatting. [REDACTED] was asked daily up until the day [REDACTED] disappeared if [REDACTED] was okay and every response was positive. [REDACTED] told family and staff that [REDACTED] left because [REDACTED] had court the next day and the situation was embarrassing to [REDACTED]. Staff had called the psychiatrist immediately and informed Human services of the situation and the doctor thought an appt in a week was okay.~~

Upon learning of Resident [REDACTED]'s disappearance on 8/10/2025, emergency protocols were activated, including local authorities' involvement, leading to the safe return of the resident.

Resident [REDACTED] was sent out by ambulance to the ER, evaluated by psychiatrist immediately upon return and readmitted for inpatient psychiatric treatment due to the severity of [REDACTED] intrusive thoughts. On 8/15/2025, all direct care staff, , received refresher training on the home's emergency response procedures for residents exhibiting intrusive or harmful thoughts.

Training included: Recognizing warning signs. Documentation and escalation protocols. Using de escalation and positive intervention strategies. The home implemented a protocol for formal documentation of family reported concerns as of 8/16/2025.

All reports of behavioral concerns from family must now be logged in the resident's chart and escalated to the Administrator or designated person.

Tools staff can use are, mood tracking, recent behavioral incidents, staff/family concerns, and follow up actions.

(please let me know if you don't get the attachment, my thumb dive is acting up)

Proposed Overall Completion Date: 10/06/2025

Licensee's Proposed Overall Completion Date: 10/06/2025

Implemented [REDACTED] 02/10/2026)

225c - Additional Assessment

9. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [REDACTED] most recent assessment was completed on [REDACTED]. On [REDACTED] 5, Resident [REDACTED] exhibited behaviors of wanting to physically harm people, the home has not completed a new assessment for resident [REDACTED].

225c Additional Assessment (continued)**Plan of Correction****Accept** [REDACTED] **- 10/02/2025)**

On 8/14/25 a add on was put on the Rasp regarding resident [REDACTED] having intrusive thoughts. A reassessment of the resident was completed to address the change in behavior and to determine new care needs, plan and supports. All direct care staff were retrained on 9/1/25 on how and when to add significant changes to a RASP. The home already does monthly MAR audits that will continue.

Licensee's Proposed Overall Completion Date: 09/22/2025**Implemented** [REDACTED] **- 02/10/2026)**