

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

June 4, 2026

[REDACTED], LICENSING
BH GLEN MILLS MANAGEMENT PA LLC
[REDACTED]
[REDACTED]

RE: MERRILL GARDENS AT GLEN MILLS
52 BALTIMORE PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14670

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/24/2026, 02/25/2026 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: MERRILL GARDENS AT GLEN MILLS **License #:** 14670 **License Expiration:** 10/16/2026
Address: 52 BALTIMORE PIKE, GLEN MILLS, PA 19342
County: DELAWARE **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: BH GLEN MILLS MANAGEMENT PA LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I 1 **Date:** 11/20/2019 **Issued By:** Chester Heights Borough

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 128 **Waking Staff:** 96

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Incident **Exit Conference Date:** 02/25/2026

Inspection Dates and Department Representative

02/24/2026 On Site: [REDACTED]
02/25/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 120 **Residents Served:** 86

Secured Dementia Care Unit

In Home: Yes **Area:** Garden House **Capacity:** 20 **Residents Served:** 19

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 86
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 42 **Have Physical Disability:** 0

Inspections / Reviews

02/24/2026 - Full

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 04/02/2026

Inspections / Reviews *(continued)*

04/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/03/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 04/16/2026

04/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/03/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/07/2026

06/04/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/03/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

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

On 2/9/2026, at approximately 9:30 AM, staff person A exited the SDCU, holding the door and allowing resident 1 to follow them while talking with each other. Staff person A reported that they were not familiar with this person and did not initially recognize that they were a resident of the SDCU. Resident 1 explained to staff person A that they had come to the home to visit [REDACTED] but did not want to wait for [REDACTED] to finish their breakfast and needed to leave. While chatting with resident 1, staff person A began to believe [REDACTED] maybe a resident from the SDCU due to some of the responses they gave while talking. Resident 1 exited the building and began walking through the parking lot. Concerned, staff person A followed resident 1 into the parking lot and watched resident 1 walk towards Route 1, which is a divided 4 lane highway, with a speed limit of 45 mph. Resident 1 was walking very fast and staff person A could not run to catch up to the resident due to [REDACTED]. The parking lot and surrounding sidewalks were clear of snow, however, after a heavy snow fall on 1/26/26, there were large 5-foot-high piles of plowed/shoveled snow around the perimeter of the parking lot. These snow piles limited staff person A's ability to maintain sight of resident 1. When staff person A lost sight of resident 1, and was unable to catch up to the resident, staff person A returned to the building to alert staff of resident 1's elopement. Resident 1 was wearing a thick sweater, long pants and holding a personal bag. The temperature of the day was a high of 31 degrees and a low of 11 degrees.

During this time, another staff person called over the walkie system that a memory care resident exited the building, alerting Staff person B, C, and D, who responded for the elopement.

Staff person C exited the building running toward a nearby store, while staff person B exited the front of building and witnessed resident 1 on the sidewalk of a restaurant next door in the other direction. Staff person B observed Resident 1 flagging down a commercial truck. The driver stopped and was talking to resident 1. When staff person B reached the truck, resident 1 was already inside the cab of the vehicle. Resident 1 refused to exit the vehicle. Staff person B explained to the driver that the resident had eloped from the SDCU. The truck driver agreed to bring resident 1 back to the entrance of the home, however, Rt 1 is a divided highway with a large barrier in the middle. To return to the main entrance of the home, the truck driver had to drive approximately 1/4 of a mile to the nearest light, complete a U-turn, drive another 1/2 mile back on the other side of Rt 1 complete another U-turn and drive another 1/4 mile to the entrance of the home. This drive took approximately 4 minutes and resident 1 was alone in the vehicle with the driver. The driver returned resident 1 to the front of the building where resident 1 remained upset and was screaming that people were trying to kidnap [REDACTED] and [REDACTED] wanted to go to the police station. Staff person D spent approximately, 10 minutes convincing resident 1 to exit the truck driver's cab. Resident 1 eventually exited the truck when staff person D said they that were at the police station.

Resident 1's assessment, dated [REDACTED], does not include an accurate need for supervision inside the home due to the resident's wandering and exit seeking behaviors. Their assessment indicates that resident 1 does not have a history of wandering, and the need for supervision is listed as "needing assistance of staff to evacuate in an emergency". There is nothing specific to the plan for supervision for the resident when within the home or mention of the residents wandering or exit seeking behaviors. Resident 1's progress notes also detail that resident 1 was demonstrating exit-seeking behavior on 12/26/2025, 12/27/2025, and 1/4/2026. On 1/7/2026. resident 1's chart notes indicate that resident 1 "is still an elopement risk". The resident's assessment and support plan were not updated to reflect the changes in the resident's need for supervision and wandering tendencies.

42b Abuse (continued)

Plan of Correction

Accept ([REDACTED]) - 04/14/2026

The resident was new to the Memory Care Unit. Most residents do have an adjustment period, where they are wandering around the unit, looking for their families. Resident #1 did not have an elopement event until 2/9/26. This was an unfortunate incident with no injuries to the resident. There was a RASP addendum completed to reflect the elopement.

Designee/HSD/GM will conduct OAPSA training for all team members and provide retraining for all team members on elopement procedures by 4 30 26.

Memory Care Director and HSD will continue to conduct monthly elopement drills in Memory Care, alternating times of day each month through 7 7 2026.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented ([REDACTED]) - 06/04/2026

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 [REDACTED] Staff person E posted a video on [REDACTED] public social media account of residents 2, 3 and 4 sitting in the home's common area of the SDCU. This video had no sound, but residents are clearly visible. A second video was also posted of staff person E speaking with resident 5. In the video resident 5's face is not visible, but staff person E could be heard saying resident 5's first name and that they would get resident 5 a drink. The staff person took this video/audio and posted it without permission of the residents.

Plan of Correction

Accept ([REDACTED]) - 04/14/2026

On [REDACTED] when the Health Service Director and General Manager were notified of the incident the home immediately terminated staff member E.

Reportable incident completed as per regulation

Designee/HSD/GM in process of conducting in service training with all staff on the company's policy on social media to be completed by 4 30 26

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented ([REDACTED]) - 06/04/2026

62 - Contact List

4. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

[REDACTED] the administrator, maintains a list of staff persons that does not include themself and substitute personnel.

62 - Contact List (continued)

Plan of Correction

Accept (█) - 04/14/2026

When the Surveyors identified the current list of employees did not include the administrator or substitute personnel - the administer generated a new current list to reflect the administrator and the substitute personnel. The new list took a bit of time to generate. The list is now up-to-date and current. The designee/BOD will update the list as new team members are hired. New hires will be reviewed weekly by BOD to ensure they are added to the master list. Beginning 4-7-26 through 7-7-26 Designee/GM will review the list monthly for accuracy beginning 4-7-26 through 7-7-26 Designee/Regional will conduct a random monthly audit to ensure compliance when on site beginning 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented (█) - 06/04/2026

63a - First Aid/CPR Training

5. 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 2/8/2026, from 11:00 PM to 7:00 AM, 81 residents were present in the home. During this time only one staff person was present in the home who was certified in first aid.

Repeat Violation: 2/25/25 et al

Plan of Correction

Accept (█) - 04/14/2026

First aid training conducted for 20 care staff on 4-7-26 by █

Designee/Garden House Director completes weekly care schedule and will ensure there are at minimum two team members certified in CPR and First Aid scheduled each shift starting 4-7-26 through 7-7-26 Designee/HSD will review schedule weekly to verify compliance 4-7-26 through 7-7-26 Designee/GM will conduct random bi-monthly audits of schedules to ensure compliance starting 4-7-26 through 7-7-26 Designee/Regional will conduct random audit monthly when on site to verify compliance. 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/15/2026

Implemented (█) - 06/04/2026

65e - 12 Hours Annual Training

6. Requirements

2600.

- 65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

65e - 12 Hours Annual Training (continued)

Description of Violation

Direct care staff person G received only 9 hours of annual training in training year 1/1/2025-12/31/2025.

Plan of Correction

Accept () - 04/14/2026

Staff person G is in process of completing the remaining 3 hours of the 12-hour required training - by 4-30-26
GHD/HSD to review assigned staff training monthly to ensure all staff are compliant. 4-7-26 through 7-7-26
Designee/GM to randomly audit staff training files to ensure up to date. 4-7-26 through 7-7-26
Designee/Regional will conduct random monthly audit when on site to verify compliance. 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented () - 06/04/2026

65f - Training Topics

7. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person G did not receive training in personal care service needs of the resident, and, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, safe management techniques during training year 1/1/2025-12/31/2025.

Repeat Violation: 2/25/25 et al

Plan of Correction

Accept () - 04/14/2026

Staff person G is in process of completing the remaining 3 hours of the 12-hour required training - by 4-30-26
GHD/HSD to review assigned staff training monthly to ensure all staff are compliant. 4-7-26 through 7-7-26
Designee/GM to randomly audit staff training files to ensure up to date. 4-7-26 through 7-7-26
Designee/Regional will conduct random monthly audit when on site to verify compliance. 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented () - 06/04/2026

65g - Annual Training Content

8. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

65g - Annual Training Content (continued)

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person G did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, and falls and accident prevention during training year 1/1/2025 to 12/31/2025.

Repeat Violation: 2/25/25 et al

Plan of Correction

Accept (█) - 04/14/2026)

Staff person G is in process of completing the remaining 3 hours of the 12-hour required training - by 4-30-26
GHD/HSD to review assigned staff training monthly to ensure all staff are compliant. 4-7-26 through 7-7-26
Designee/GM to randomly audit staff training files to ensure up to date. 4-7-26 through 7-7-26
Designee/Regional will conduct random monthly audit when on site to verify compliance. 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented (█) - 06/04/2026)

100b - Removal Snow/Obstructions

10. Requirements

- 2600.
- 100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 2/24/2026 at 10:55 AM, there were large patches of snow and ice throughout the memory care patio, between and under tables and chairs. The largest patches of snow were wavey in shape and approximately 10 feet long by 6 feet wide and 1 inch deep, and the patches of ice were approximately 2 feet by 2 feet. It last snowed approximately 10 inches on 2/23/2026.

Plan of Correction

Accept (█) - 04/14/2026)

This annual survey occurred less than 24-hours after a Pennsylvania Snow Emergency. All 8 egress areas were shoveled and cleared as per regulations.
Snow has since melted.
Designee/Maintenance Director will ensure memory Care patio is free of snow during inclement weather.

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented (█) - 06/04/2026)

103g - Storing Food

11. Requirements

- 2600.

103g - Storing Food (continued)

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 2/24/2026 there was an open and unsealed bag of raw shrimp stored next to cooked food in the home's walk-in refrigerator.

Repeat Violation: 2/25/25 et al

Plan of Correction

Accept () - 04/14/2026)

Dining Director conducted in-service for all dining staff reminding them all food must be labeled and dated and stored in closed or sealed containers.

Designee/Dining Director will conduct weekly audits of all food storage areas weekly x 3 months. 4-7-26 through 7-7-26

Designee/GM will conduct random bi-monthly audits of the food storage area to ensure compliance. 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented () - 06/04/2026)

103i - Outdated Food

12. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 2/24/2025 There was an unlabeled, undated container of cooked eggs noodles and unsealed, unlabeled, and undated pickles in the walk-in refrigerator. There was also a container of cooked rigatoni dated 2/15/2026. Cooked pasta should be consumed or discarded 3 to 5 days after preparing.

Repeat Violation: 2/25/25 et al

Plan of Correction

Accept () - 04/14/2026)

Dining Director conducted in-service for all dining staff reminding them all food must be labeled and dated and stored in closed or sealed containers and outdated or spoiled food or dented cans may not be used.

Designee/Dining Director will conduct weekly audits of all food storage areas weekly x 3 months. 4-7-26 through 7-7-26

Designee/GM will conduct random bi-monthly audits of the food storage area to ensure compliance. 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented () - 06/04/2026)

103j - Utensils Cleaning

13. Requirements

2600.

103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

103j Utensils Cleaning (continued)

Description of Violation

On 2/24/2025 two large, slotted spoons that were previously used to serve fruit during a prior meal and were stored on top of containers of peaches and pears in the refrigerator. There was visible dried food debris on the spoons and staff interviewed stated these were not cleaned after each meal.

Plan of Correction

Accept () - 04/14/2026

Dining Director conducted in service for all dining staff reminding them all food must be labeled and dated and stored in closed or sealed containers and outdated or spoiled food or dented cans may not be used and utensils shall be washed, rinsed, and sanitized after each use.

Designee/Dining Director will conduct weekly audits of all food storage areas see specific attached audit weekly x 3 months. 4 7 26 through 7 7 26

Designee/GM will conduct random bi monthly audits of the food storage area to ensure compliance. 4 7 26 through 7 7 26

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented () - 06/04/2026

123b - Emergency Procedures Posted

14. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction

Accept () - 04/14/2026

The Community has signage posted at the front desk stating if you would like to see the home's Emergency Procedures it is located at the front desk.

The Emergency Procedure binder is now on top of the counter at the front desk .

Concierge to check daily to ensure Emergency binder in place

Designee/HSD to conduct random audits weekly to ensure binder in place on top of counter weekly x 3 months 4 7 26 through 7 7 26

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented () - 06/04/2026

162e - Menu Changes

15. Requirements

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 2/25/2026, mushroom and peas, and lemon cream cake were listed on the menu for the lunch meal. Broccoli and strawberry cake was served instead. No notice was provided to the residents in advance of the meal.

162e Menu Changes (continued)

Plan of Correction

Accept () - 04/14/2026

Dining Director conducted in service for all dining staff letting them know that any changes to the menu must be posted for the residents to view. Listing what food item has changed. In service completed see attached training Designee/Dining Director will maintain a record of any changes to the scheduled menus and maintain a binder showing the printed changes for the residents. Starting 4 7 26 through 7 7 26 Designee/GM will randomly audit the meals for any changes to menu weekly x 3 month. 4 7 26 through 7 7 26

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented () - 06/04/2026

181d -Storing Medication

16. Requirements

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 6 self administers medications and stores medications in room. Resident 6 resides with that has not been assessed as unable to self administer medications.

On 2/25/2026 at approximately 1:00 PM, there were several unlocked, unattended medications to include folic acid tab 400 mcg, gabapentin cap 100 mg and levothyroxine tab 125 mcg in resident 6's shared bedroom.

Plan of Correction

Accept () - 04/14/2026

Locks were placed on the cabinets next to resident #6's bed to ensure safety. immediately by POA. This is an isolated incident as there are no living together where one self administers and the other does not. Designee/GHD/HSD to ensure moving into community and self administer have medications locked in the apartment Designee/GM will randomly audit new residents that self administer to ensure compliance monthly x 3 months 4 7 26 through 7 7 26

Licensee's Proposed Overall Completion Date: 04/07/2026

Implemented () - 06/04/2026

236 - Staff Training

18. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person G, who works in the Secure Dementia Care Unit (SDCU) had only 2.5 hours of training in dementia care during the 1/1/2025 to 12/31/2025 training year.

Plan of Correction

Accept () - 04/14/2026

Staff person G is in process of completing the remaining 3.5 hours of the 6 hour required training by 4 30 26

236 - Staff Training (continued)

GHD/HSD to review assigned staff training monthly to ensure all staff are compliant. 4-7-26 through 7-7-26
Designee/GM to randomly audit staff training files to ensure up to date. 4-7-26 through 7-7-26
Designee/Regional will conduct random monthly audit when on site to verify compliance. 4-7-26 through 7-7-26

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented ([REDACTED]) - 06/04/2026)

252 - Record Content

19. 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.
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 7's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction

Accept ([REDACTED]) - 04/14/2026)

Resident # 1's photo was immediately taken and uploaded into EHR.

252 Record Content (continued)

*Designee/GHD/HSD to conduct an audit of all resident photos by 4 30 26 to ensure compliance
There will be a scheduled photo day for all residents annually to ensure full compliance scheduled for May 15th.*

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented ([REDACTED] - 06/04/2026)