



Sent via e-mail bbacon@brandycare.com
Sent via e-mail pfusaro@brandycare.com
October 28, 2019

Ms. Mary Ellen Pisanelli
Authorized Signatory
WELL BL OPCO, LLC
Attn: Brenda Bacon
525 Fellowship Road, Suite 360
Mount Laurel, New Jersey 08054

RE: Brandywine Senior Living at Longwood
301 Victoria Gardens Drive
Kennett Square, Pennsylvania 19348
License #: 144300

Dear Ms. Pisanelli:

As a result of the Department's Bureau of Human Services Licensing inspection on July 2, 2019 and September 25, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa. Code Ch. 2600 must be maintained.

Sincerely,

Shawn Parker

Shawn Parker
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: BRANDYWINE LIVING AT LONGWOOD

License Number: 14430

Address: 301 VICTORIA GARDENS DRIVE, KENNETT SQUARE, PA 19348

County: CHESTER

Region: SOUTHEAST

Administrator

Name: Paola Fusaro

Phone: 4847346200

Email: pfusaro@BRANDYCARE.COM

Legal Entity

Name: WELL BL OPCO LLC

Address: 525 FELLOWSHIP ROAD SUITE 360, ATTN BRENDA BACON, MOUNT LAUREL, NJ, 8054

Certificate(s) of Occupancy

Type: I-1

Date:

Issued By:

Staffing Hours

Resident Support Staff:

Total Daily Staff: 106

Waking Staff: 80

Inspection

Type: Partial

BHA Docket #:

Notice: Unannounced

Reason: Incident

Inspection Dates and Department Representative

07/02/2019 - On-Site: Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 92

Residents Served: 68

Secured Dementia Care Unit

In Home: Yes

Area: Reflections

Capacity: 23

Residents Served: 21

Hospice

Current Residents: x

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 68

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 38

Have Physical Disability: 3

23a - Activities of Daily Living Assistance

Regulations

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 resident assessment support plan (RASP), dated 05/02/2019, for resident #1 indicates the resident requires assistance with bladder and bowel management. On 06/14/2019, direct care staff person A ignored resident #1's repeated requests for using the bathroom before going to the activity program.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.23.a. A RASP document and assignment sheets are completed to inform staff members about details regarding individualized care needs for each resident. The staff member was aware of the resident's care needs as indicated on the RASP and on 6/14/19 did toilet the resident several times before lunch with no output success. The resident stated that she needed to use the bathroom when asked to attend an afternoon activity but the staff member did not attempt to toilet the resident again before the activity. The staff member tried to redirect the resident about going to the activity rather than taking the time to attempt toileting the resident again. As a result, the staff member was terminated for failing to complete the toileting with which the resident required assistance.

Mandatory staff meetings were conducted throughout July for all staff to review the Brandywine T.R.U.S.T. Pledge and Brandywine standards as well as staff expectations, conduct and treatment of residents. A T.R.U.S.T. Pledge was reviewed and signed by all staff members attending the meetings. By 8/30/19, all staff members will have the Brandywine T.R.U.S.T. Pledge reviewed and signed and placed in personnel file. (See Attachment A)

By August 30, 2019, staff meetings will be conducted with the Wellness Nurses and Care Managers to review the Assignment sheets and the care needs of Residents as indicated on the RASP.

The Executive Director or Designee will continue to review the T.R.U.S.T. pledge upon hire and monthly with staff, during the monthly communication meeting. The Wellness Director or Designee will continue to keep the assignments sheets updated with the resident care needs as indicated on the RASP.

Please see attached.....

Legal Entity Representative

Signature: Paola Fusaro, RN

Printed Name and Title: PAOLA FUSARO, Executive Director Date: 8/20/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

Approval and implementation status section with checkboxes for Fully Implemented, Partially Implemented - Adequate Progress, Partially Implemented - Inadequate Progress, and Not Implemented. Includes date fields for approval and implementation.

2600.23a

Home provided verification of T.R.U.S.T. pledge form and that staff were educated to resident's rights. Administrator or designee will ensure direct care staff are familiar with resident assessment support plans (RASP) and providing ADL assistance in accordance with RASP.

SP 10-24-19

42b - Abuse

Regulations

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

It was reported by staff person B that on 06/14/2019 at approximately 02:15 PM, direct care staff person A ignored resident #1's repeated requests for bathroom assistance. Resident #1 wanted to participate in a karaoke activity that was scheduled to take place but wanted to go to the bathroom first. Staff person B who is an activity aid, also informed staff person A that resident # 1 was requesting help going to the restroom before the activity began. Staff person A was preoccupied on the phone, but told staff person B resident #1 has already been taken to the bathroom and was just "passing gas". This was a false statement as Staff person A never took resident #1 to the bathroom. She continued her conversation on the phone ignoring the request of resident #1 and staff person B. Staff person A while still on the phone, asked resident #1 three times "don't you want to go to karaoke?" Each time the resident responded they wanted to go to the bathroom first. Staff person A never obliged or assisted the resident. Finally resident #1 gave up on going to the activity. Staff person A while still on the phone told resident #1, "I'm not playing games with you anymore".

On 06/14/2019 at approximately 1:30 PM, staff person A, who was talking on her cell phone at the time with someone on a speaker, addressed resident #2 who was dozing at a table in an inappropriate way. Staff person A spoke to the resident using profane language.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

** Please see Plan of Correction on attached separate sheet

Legal Entity Representative

Purea Fusaned, NHA
Signature

Purea Fusaned, Executive Director 8/20/19
Printed Name and Title Date

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The above plan of correction is approved as of 10-24-19
(Date)

Plan of correction implementation status as of 10-24-19
(Date)

The above plan of correction was approved by SP
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.42.b. –Abuse

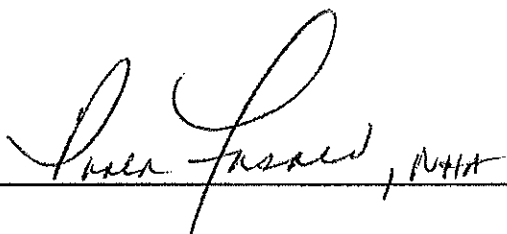
PLAN OF CORRECTION (POC)

Brandywine Living is committed to providing the highest level of quality care to our residents. Brandywine Living also has a zero tolerance policy for any type of Resident abuse or violation of Resident Rights. On 6/14/19, Staff Member B reported a verbal abuse situation they witnessed between Care Manager A and Resident #1 and Resident #2. An investigation was immediately initiated and Care Manager A was immediately suspended and subsequently terminated. The family of Resident #1 and Resident #2 were notified and the residents were also interviewed and found to have no recollection of the interaction or negative outcome as a result.

Mandatory in-services were immediately started for all staff to review Resident Rights, Resident Abuse and reporting, and the community cell phone policy. Our company T.R.U.S.T. Pledge which is our company zero tolerance policy statement pledge, was signed by all staff members attending the mandatory in-services. (See Attachment F)

The mandatory in-services for all staff members (ft, pt AND Per Diem) will continue and will be completed by 8/30/19.

The Executive Director or Designee will be responsible for reviewing the Resident Abuse policy and reporting, Resident Rights and Cell Phone policy upon hire and during orientation as well as during monthly staff meetings throughout the year.

Signature: 

Printed Name and Title: PAOLA FUSARO Executive Director

Date: 8/20/19

Home provided verification of T.R.U.S.T. pledge form and that staff were educated to resident's rights. Administrator or designee will ensure any allegations of abuse will be managed in accordance with the Older Adult Protective Services Act including: reporting, suspension or supervision of staff and investigation.

65d - Initial Direct Care Training

Regulations

2600.

65.d.2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

On 07/02/2019, staff person B, who is an activity aid, was seen pushing resident #1 in her wheelchair to an activity. Staff person B has not completed the Department approved direct care training course or passed the competency test.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.65d Initial Direct Care Training

The Department approved direct care training and competency test is and has always been completed by all Wellness staff as part of the hiring process.

Effective Immediately, all newly hired staff members in all departments will be required to complete the direct care training and competency test as pushing a wheelchair would be expected by all staff members when needed as well as in an emergency situation.

By 9/30/19, all current staff members will have the Department approved direct care training and competency test completed and a certificate will be placed in the personnel file. Staff member B completed the competency test and the certificate is attached. (Attachment D)

The Human Resources Director or Designee will be responsible for ensuring the completion of the direct care competency test as part of the hiring process for all staff. A completed certificate will be maintained in the personnel records. An audit of all new hires will be completed and submitted monthly in the QA meeting. Please see attached.....

Legal Entity Representative

Paula Fusco, NHA
Signature

Paula Fusco Executive Director
Printed Name and Title

8/20/19
Date

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(Date)

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(Date)

The above plan of correction was approved by SP
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.65d2

Home provided verification staff member b has been direct care trained and passed the Department approved direct care training course and competency test. Administrator or designee will ensure inly trained staff provide direct care services to residents.

SP 10-24-19

101j7 - Lighting/Operable Lamp

Regulations

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 #2 has a tap light as a source of light that can be turned on/off at bedside, but on 07/02/2019 the tap light was not working.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.101j7- Lightning/Operable Lamp

The bedside lighting in Resident #2 was immediately replaced and is operable. An audit of all resident bedside lighting was completed on 7/2/19, after the inspection, and all bedside lighting was in place and operable. (See Attachment B)

The Environmental Services Director or Designee will be responsible for completing a monthly audit of all apartments to ensure all resident bedside lighting is in place and operable. The audit will be reviewed and submitted in the monthly QA meeting. (See Attachment C)

Home provided verification of bedside lighting audit and monthly checklist. Administrator or designee will ensure all residents have a source of light that can always be turned on/off from bedside. Checklist to be made available for Department review. SP 10-24-19

Legal Entity Representative

Signature: *Paola Fusaro, MHA*

Printed Name and Title: PAOLA FUSARO, Executive Director

Date: 8/20/19

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Plan of correction implementation status as of 10-24-19 (Date)

The above plan of correction was approved by SP (Initials)

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- Partially Implemented - Inadequate Progress
- Not Implemented

231e - No Objection Statement

Regulations

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on 05/17/2018. The home has no documentation that the resident has not objected to the admission.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.231.e.- No Objection Statement

Residents admitted or transferred to the Secured Dementia Unit (SDU) will have documentation in their resident record indicating that the resident and resident's designated person have not objected to admission to the SDU.

Resident #2 had a consent form signed by the physician and resident's Power of Attorney as the resident was in and out of the hospital at the time of the transfer to the SDU. The consent form was reviewed and signed by Resident #2 at the completion of the survey on 7/2/19. (See Attachment E)

The Wellness Director or Designee will be responsible to ensure the proper required documentation regarding no objection of a resident and resident's designated person to the SDU is completed upon admission or transfer to the SDU. A monthly audit of admissions and transfers to the SDU will be completed monthly and reviewed in the monthly QA meeting.

Legal Entity Representative

Paola Fusaro, NHA
Signature

PAOLA FUSARO, Executive Director
Printed Name and Title

8/20/19
Date

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- Not Implemented

2600.231e

Home did provide documentation that resident #2 has an no objection statement signed by a physician and a legal representative. Within 30 days receipt of POC administrator or designee will review all records of SDCU residents to ensure they all have an no objection statement signed by the persons specified in regulation 2600.231e

SP 10-24-19

Violation Report

Facility Information

Name: BRANDYWINE LIVING AT LONGWOOD

License Number: 14430

Address: 301 VICTORIA GARDENS DRIVE,, KENNETT SQUARE, PA 19348

County: CHESTER

Region: SOUTHEAST

Administrator

Name: Paola Fusaro

Phone: 4847346200

Email: BBACON@BRANDYCARE.COM

Legal Entity

Name: WELL BL OPCO LLC

Address: 525 FELLOWSHIP ROAD, SUITE 360, ATTN BRENDA BACON, MOUNT LAUREL, NJ, 8054

Certificate(s) of Occupancy

Type: Other

Date:

Issued By:

Staffing Hours

Resident Support Staff: 121

Total Daily Staff: 242

Waking Staff: 182

Inspection

Type: Partial

BHA Docket #:

Notice: Unannounced

Reason: Monitoring

Inspection Dates and Department Representative

09/25/2019 - On-Site: Jennie Heinberg

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 92

Residents Served: 67

Secured Dementia Care Unit

In Home: Yes

Area: reflections

Capacity: 20

Residents Served: 19

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 67

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 54

Have Physical Disability: 7