



Sent via e-mail bbacon@brandycare.com
Sent via e-mail imonteith@brandycare.com
November 19, 2019

Mr. Mark Gellert
Executive Director
WELL BL OPCO, LLC
525 Fellowship Road, Suite 360
Mount Laurel, New Jersey 08054

RE: Brandywine Senior Living at Haverford Estates
731 Old Buck Lane
Haverford, Pennsylvania 19041
License #: 144330

Dear Mr. Gellert:

As a result of the Department's Bureau of Human Services Licensing inspection on August 12, 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,

Sandra Wooters

Sandra Wooters, MHS, ACG
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: *BRANDYWINE LIVING AT HAVERFORD ESTATES*
 Address: *731 OLD BUCK LANE,, HAVERFORD, PA 19041*
 County: *DELAWARE* Region: *SOUTHEAST*

License Number: *14433*

Administrator

Name: *Ian Montieth* Phone: *6105271800* 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: *C-2 LP* Date: Issued By:

Staffing Hours

Resident Support Staff: Total Daily Staff: *104* Waking Staff: *78*

Inspection

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

Inspection Dates and Department Representative

09/12/2019 - On-Site: Sandi Wooters

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *118* Residents Served: *79*

Secured Dementia Care Unit

In Home: *Yes* Area: *Reflections* Capacity: *25* Residents Served: *20*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *78*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *25* Have Physical Disability: *25*

17 - Record Confidentiality

Regulations

2600.

- 17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

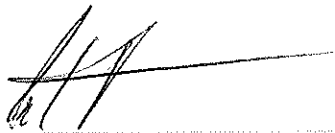
At 10:09am the lap top, located on the 3rd floor, was unlocked and unattended with the computer screen partially open with resident information.

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.)

SEE ATTACHED PLAN OF CORRECTION

Legal Entity Representative



Signature

Jan C. Monteith ED

Printed Name and Title

9/27/19

Date

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

The above plan of correction is approved as of 10/2/19 (Date)

Plan of correction implementation status as of 10/3/19 (Date)

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

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

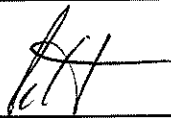
Brandywine Living

Plan of Correction

Name of Community: Brandywine - Haverford Estates
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License Number: 144330
Inspection date(s): 12-Sep-19
Name and Title of Brandywine representative Signing the Plan of Correction:
Ian Monteith E.D.

Signature of Representative:

Date of Submission:


10/2/19

Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.17	9/12/2019	Wellness Nurse has been terminated
	9/18/2019	IPPC Pharmacy completed staff training on proper medication management and medication errors
	Ongoing	IPPC Pharmacy to complete medication pass with each wellness nurse quarterly for one year.
	12/18/2019	Violation to be reviewed at Quality Improvement meeting. Violation of policy and any corrective action taken in previous quarter will be reviewed.
	10/31/2019	All nurse will attend mandatory training on HIPAA compliance and the use of EMAR laptops to include shielding laptop screen when in use and procedure for when cart is unattended.
	Ongoing	Management team to check for HIPAA violations with EMAR laptop and medication cart security on a daily basis.

88a - Surfaces

Regulations

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The delayed egress door located on the 1st floor SDCU did not open within 15 seconds when pressed.

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Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.88a	9/13/2019 9/27/2019 12/18/2019	Current Technologies onsite to review and assess egress door Repairs to proceed when immediately when parts available ED to submit completed work order post repair. Tentative date of completion set for 10/3/2019. Environmental Services Director will document egress checks weekly in TELs program Violation to be reviewed at Quality Improvement meeting.

103e - Left Overs

Regulations

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 10:05 am, there was a tray of individual pasta salad located in the walk in freezer not labeled.

At 10:26 am an open can of diet cola was located in the 1st floor SDCU refrigerator.

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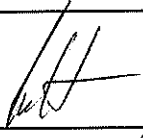
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Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.103e	9/12/2019	All items discarded
	9/20/2019	Dining Services Director or Chef to check food storage areas for compliance daily in kitchen and memory care
	9/27/2019	Compliance check to be added to Chef work flow sheets
	10/31/2019	All staff to be trained on regulation 103e in regard to items labeled in refrigerator.
	12/18/2019	Violation to be reviewed at Quality Improvement meeting. Violation of policy and any corrective action taken in previous quarter will be reviewed.

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill conducted on June 24, 2019, at 5:33am, documented 17 staff participated in the drill. On this date there were only four staff signed in as participating in the drill and on the schedule.

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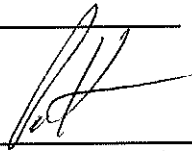
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Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.132c	9/12/2019	Surveyor provided with fire drill records from 6/27 that was complete indicating a corrected drill for the month of June, 2019. (slw 10/3/9)
	9/12/2019	Executive Director and Environmental Services Director to review monthly report(s) for typos and compare the staff sign in with those actually in attendance the day of the drill. (slw 10/3/19)
	Ongoing	Any noted issues will be require immediate correction by Fire Safety Solutions
	12/18/2019	Violation to be reviewed at Quality Improvement meeting.

183b - Meds and Syringes Locked

Regulations

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 10:08 am, the medication cart located on the 3rd floor was unlocked and unattended.

At approximately 10:30am, there was a small white pill found on the 2nd floor hallway carpet.

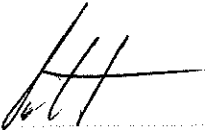
At approximately 2:00 pm, there was a white pill in a medication cup found on the night stand in room 319. The Resident #1 residing in this room is unable to self administer medications.

Plan of Correction (POC)

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Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.183b	9/26/2019	Wellness Nurses to attend training on med disposal
	9/18/2019	IPPC Pharmacy completed staff training on proper medication management and medication errors
	Ongoing	IPPC Pharmacy to complete medication pass with each wellness nurse quarterly for one year.
	12/18/2019	Violation to be reviewed at Quality Improvement meeting. Violation of policy and any corrective action taken in previous quarter will be reviewed.
	9/12/2019	Medications noted in 2600.183b were destroyed as per policy.
	10/1/2019	Nurses to ensure resident drinks a full glass of fluid when administering medications.
	10/31/2019	All nurse to attend mandatory in-service on having medication secured or within reach at all times.
	10/31/2019	All nurse to attend mandatory training on medications not being left at bedside without a physician order.
	Weekly	Director of Nurses will conduct periodic physical site checks of resident rooms and hallways to ensure all medications administered are still not on the bedside table or hallway. (slw)

184b - Resident's Meds Labeled

Regulations

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

At approximately, 2:10 pm, OTC medication Vitamin C was not labeled with Resident #1's name.

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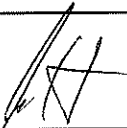
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Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.184b	9/18/2019	IPPC Pharmacy completed staff training on proper medication management and medication errors
	Ongoing	IPPC Pharmacy to complete medication pass with each wellness nurse quarterly for one year.
	10/1/2019	Nightly cart audits to be completed by wellness nurse
	10/31/2019	All nurses required to attend mandatory training on how to complete and document a medication cart audit.
	12/18/2019	Violation to be reviewed at Quality Improvement meeting. Violation of policy and any corrective action taken in previous quarter will be reviewed.
	10/31/2019	All nurses to attend mandatory training on proper labeling of all medications per medication administration policy.
	9/12/2019	The medication was labeled with the residents name immediately following discovery of the unlabeled medication. (slw 10/3/19)

227d - Support Plan Medical/Dental

Regulations

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1 requires assistance with personal hygiene. The residents support plan dated August 8, 2010 did not provide direction on how the staff will meet this need.

Plan of Correction (POC)

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Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.227d	9/20/2019	RASP updated to reflect verbal cueing for resident hygiene
	Ongoing	Wellness Director or designee will audit and ensure RASPs are current and have identified current resident needs in addition to how staff will meet the needs, at least quarterly, starting immediately. (slw 10/3/19)
	12/18/2019	Violation to be reviewed at Quality Improvement meeting. Violation of policy and any corrective action taken in previous quarter will be reviewed.

227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 did not date his Support Plan dated July 20, 2019.

Plan of Correction (POC)

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Signature

Ian Monteith ED 9/27/19
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Regulation	Target Date by Which Correction will be Completed	Plan of Correction
2600.227g	Ongoing	Wellness Director and reflections Coordinator will review all future RASPs for signature and date
	10/31/2019	RASP audits to be conducted by Wellness Director and Reflections Coordinator for all residents
	12/18/2019	Violation to be reviewed at Quality Improvement meeting. Violation of policy and any corrective action taken in previous quarter will be reviewed. Resident #2's Support Plan will be signed at dated by 10/15/19. (slw 10/3/19)