



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

# CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **AB EAST NORRITON OPERATOR LLC**

LEGAL ENTITY

To operate **BRANDYWINE SENIOR LIVING AT SENIOR SUITES**

NAME OF FACILITY OR AGENCY

Located at **2101 NEW HOPE STREET, EAST NORRITON, PA 19401**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **245**  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 50**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

**55 Pa.Code Chapter 2600: Personal Care Homes**

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 4, 2021** until **May 31, 2021**,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **144250**

  
ISSUING OFFICER

  
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**Emailing Date: March 4, 2021**

Ms. Marla Nadelstumph  
VP of Organizational Development & Program Excellence  
AB East Norriton Operator, LLC  
525 Fellowship Road, Suite 360  
Mount Laurel, New Jersey 08054

RE: Brandywine Senior Living at Senior Suites  
2101 New Hope Street  
East Norriton, Pennsylvania 19401  
License #: 144250

Dear Ms. Nadelstumph:

As the result of your home's recent request to adjust the use of the physical space, the Department has granted an approval for a revised license issued under the authority of 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The approved capacity revision request is an increase from 40 to 50. The expiration date of the license remains unchanged.

Any future requests for changes in capacity should be forwarded to the Department for review and consideration in accordance with the applicable regulations. The revised license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Jamie F. Buchenauer".

Jamie Buchenauer  
Deputy Secretary  
Office of Long-term Living

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

**Facility Information**

Name: *BRANDYWINE SENIOR LIVING AT SENIOR SUITES* License #: *14425* License Expiration Date: *05/31/2021*  
 Address: *2101 NEW HOPE STREET, EAST NORRITON, PA 19401*  
 County: *MONTGOMERY* Region: *SOUTHEAST*

**Administrator**

Name: *Jessica Gonzalez* Phone: *6102726200* Email: *jgonzalez@brandycare.com*

**Legal Entity**

Name: *AB EAST NORRITON OPERATOR LLC*  
 Address: *525 FELLOWSHIP ROAD, SUITE 360, MOUNT LAUREL, NJ, 8054*  
 Phone: *6102726200* Email: *JGONZALEZ@BRANDYCARE.COM*

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *08/27/2003* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *92* Waking Staff: *69*

**Inspection**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal,Incident* Exit Conference Date: *02/04/2021*

**Inspection Dates and Department Representative**

*02/03/2021 - On-Site: Youn Hie Chung*  
*02/04/2021 - On-Site: Youn Hie Chung*

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *245* Residents Served: *61*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Reflections* Capacity: *40* Residents Served: *17*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *60*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *31* Have Physical Disability: *0*

## Inspections / Reviews

02/03/2021 - Full

Lead Inspector: *Youn Hie Chung*Follow-Up Type: *POC Submission*Follow-Up Date: *02/27/2021*

2/26/2021 - POC Submission

Lead Reviewer: *Claire Mendez*Follow-Up Type: *POC Submission*Follow-Up Date: *02/28/2021*

3/1/2021 - POC Submission

Lead Reviewer: *Claire Mendez*Follow-Up Type: *Document Submission*Follow-Up Date: *03/22/2021*

## 42c - Treatment of Residents

## 1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

## Description of Violation

On 4/24/20, Staff person A took a picture of resident #2 during an incontinent care and posted the photo online to social media (Instagram) without the resident's knowledge or consent.

## Plan of Correction

Do Not Accept

The staff person in question was immediately terminated upon notification of incident. Executive Director ensured the post was removed from social media. All Staff was trained on cell phone usage in the building and residents rights to be treated with dignity and respect. Residents Rights to be reviewed upon hiring and quarterly. See attachment #1

Completion Date: 03/11/2021

## Update - 02/26/2021

Has all staff been trained on Resident Rights after this incident? How will compliance be monitored? How will the home ensure that residents rights are adhered to? Who will be responsible? Frequency?

## Plan of Correction

Accept

The staff person in question was immediately terminated upon notification of the incident. Executive Director ensured the post was removed from social media. All Staff will be trained on cell phone usage in the building and residents' rights to be treated with dignity and respect. Residents Rights to be reviewed upon hiring and quarterly. See attachment #1 Executive Director will ensure that all staff are trained by 3/12/2021 and will audit training records quarterly

Completion Date: 03/12/2021

## 42s - Privacy

## 1. 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 04/24/2020, Staff person A took a picture of resident #2 during incontinence care and posted the photo online to social media (Instagram) without the resident's knowledge or consent.

## Plan of Correction

Do Not Accept

The staff person in questions was immediately terminated upon notification of incident. Executive Director ensured the post was removed from social media. All Staff was trained on cell phone usage in the building and residents rights to Privacy of self and possessions. Residents Rights to be reviewed upon hiring and quarterly. See attachment 1

Completion Date: 03/11/2021

## Update - 02/26/2021

Has all staff been trained on Resident Rights after this incident? How will compliance be monitored? How will the home ensure that residents rights are adhered to? Who will be responsible? Frequency?

## 42s - Privacy (continued)

**Plan of Correction****Accept**

*The staff person in question was immediately terminated upon notification of the incident. Executive Director ensured the post was removed from social media. All Staff was trained on cell phone usage in the building and residents' rights to privacy of self and possessions. Residents Rights to be reviewed upon hiring and quarterly. See attachment 1*

*Executive Director will ensure that all staff are trained by 3/12/2021 and will audit training records quarterly.*

**Completion Date:** 03/12/2021

## 65f - Training Topics

**1. Requirements**

2600.

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

1. Medication self-administration training.
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.

**Description of Violation**

*Direct care staff person B did not receive training in the above topics during training year 2019.*

**Plan of Correction****Do Not Accept**

*Direct care staff person B is no longer direct care staff. Training plan reviewed and Direct Care Staff highlighted to ensure they have the proper annual training required including #1. Medications self-administration and #4. Infection control. Training records to be audited quarterly by Wellness Director. See attachment 2*

**Completion Date:** 02/25/2021

**Update - 02/26/2021**

*Will/when will staff person B receive training? Have all current staff records been reviewed to ensure there are no additional untrained staff providing direct care?*

**Plan of Correction****Accept**

*Direct care staff person B is no longer direct care staff. Training plan reviewed and Direct Care Staff highlighted to ensure they have the proper annual training required including #1. Medications self-administration and #4. Infection control. Direct Care Training records to be audited by 3/12/2021 by Wellness Director to ensure that all required training has been completed once the initial audit is completed the Wellness Director will audit quarterly. See attachment 2*

*Staff member B is no longer a direct care staff member.*

**Completion Date:** 03/12/2021

## 82c - Locking Poisonous Materials

**1. Requirements**

2600.

- 82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

82c - Locking Poisonous Materials *(continued)***Description of Violation**

*McKesson Fluoride toothpaste, with a manufacture's label indicating "get medical help or contact a poison control center if swallowed more than used for brushing", was unlocked, unattended, and accessible to resident #3 in the mirrored medicine cabinet in the resident's bathroom. Not all the residents of the home, including resident #3, have been assessed capable of recognizing and using poisons safely.*

**Plan of Correction****Accept**

*Tooth paste was removed from residents' room at the time of the inspection. Staff in-serviced on poisonous materials and proper storage. Reflections Coordinator to preform daily checks for the next month to ensure materials are properly stored then monthly checks going forward. See attachment 3*

**Completion Date:** 03/25/2021

## 85a - Sanitary Conditions

**1. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

*On 02/04/2021, the bathroom in resident room #340 had no means of hand drying options. The paper towel dispenser was empty and no towel was available. The bath tub/shower stall in resident room #310 was stained with pink mold.*

**Plan of Correction****Do Not Accept**

*During initial walk through of the building residents paper towel holder in room 340 was empty in the bathroom and resident's linens had not been refreshed from morning care. Resident was in the dining room having her breakfast. Housekeeping called and towels replaced prior to resident returning to her room. 310s bathroom had a pink watermark on residents tub by the drain area was cleaned during inspection and housekeeping staff retrained due to hard water in the community tubs need to be monitored for hard watermarks.*

**Completion Date:** 02/25/2021

**Update - 02/26/2021**

*How will the home ensure ongoing compliance? How often? Who will be responsible?*

**Plan of Correction****Accept**

*During the initial walk-through of the building residents, the paper towel holder in room 340 was empty in the bathroom and the resident's linens had not been refreshed from morning care. The resident was in the dining room having her breakfast. Housekeeping called and towels replaced prior to the resident returning to her room. 310s bathroom had a pink watermark on residents tub by the drain area was cleaned during inspection and housekeeping staff retrained due to hard water in the community tubs need to be monitored for hard watermarks. A daily checklist has been created to ensure compliance and will be audited weekly to verify compliance.*

**Completion Date:** 03/05/2021

## 85d - Trash Receptacles

**1. Requirements**

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles *(continued)***Description of Violation**

On 02/04/2021 around 11:00 AM, three trash cans in the home's kitchen were not covered.

**Plan of Correction****Do Not Accept**

New trash cans with lids have been purchased. Dining service director will ensure lids remain in place. See attachment 4

Completion Date: 02/25/2021

**Update - 02/26/2021**

How often will the dining service director monitor compliance, and for what duration?

**Plan of Correction****Accept**

New trash cans with lids have been purchased. The Dining Service director will ensure lids remain in place. The Dining Service Director will train staff on sanitation and ensure that staff understands why garbage cans must be covered. Trash Receptacles will be added to daily cleaning sheets. See attachment 4

Completion Date: 03/05/2021

## 101i - Access to Bedroom

**1. Requirements**

2600.

101.i. A resident shall have access to his bedroom at all times.

**Description of Violation**

On 02/03/2021 at 10:30 AM, the doors of most of the residents' rooms including room #308, 310, and 311 in the home's secured dementia unit (SDCU) were locked.

**Plan of Correction****Accept**

All doors were unlocked during walk through. Direct care staff in serviced on residents right to have access to their bedroom at all times. Reflections Coordinator to preform daily checks for the next month to ensure doors unlocked then monthly checks going forward. See attachment 3

Completion Date: 03/25/2021

## 103f - Refrigerator/Freezer Temps

**1. Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

**Description of Violation**

There was no thermometer in the ice-cream freezer in the kitchen.

**Plan of Correction****Do Not Accept**

Thermometer added during the inspection. Dining staff trained that all refrigerators and freezers require thermometers at all times. Dining Service Director to monitor placement of thermometers. See attachment 5

Completion Date: 03/11/2021

**Update - 02/26/2021**

How often will the Dining Service Director monitor compliance and for what duration?

103f - Refrigerator/Freezer Temps (*continued*)**Plan of Correction****Accept**

*Thermometer added during the inspection. Dining staff trained that all refrigerators and freezers require thermometers at all times. Dining Service Director to monitor placement of thermometers. daily for the next 30 days and then weekly after that. See attachment 5*

**Completion Date:** 03/12/2021

## 103g - Storing Food

**1. Requirements**

2600.

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

**Description of Violation**

*One of the round tubs of ice-cream in the home's kitchen ice-cream freezer was uncovered. A bag of basmati rice was open and not sealed on the home's dry storage shelf.*

**Plan of Correction****Do Not Accept**

*Lids replaced at the time of inspection and rice disposed of. Dining staff trained on the proper storage as well as proper labeling and dating of food. See attachment 5*

**Completion Date:** 03/11/2021

**Update - 02/26/2021**

*How will the home ensure that compliance is maintained?*

**Plan of Correction****Accept**

*Lids replaced at the time of inspection and rice disposed of. Dining staff trained on the proper storage as well as proper labeling and dating of food. Lids added to dining checklist. Dining Director or Dining Room Supervisor to audit daily for the next 60 days. and then weekly for the next 3 months. See attachment 5*

**Completion Date:** 03/12/2021

## 183e - Storing Medications

**1. Requirements**

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

**Description of Violation**

*On 02/04/2021, there was a bottle of Timolol Maleate eye drop, prescribed for resident #4, with an open date of 12/11/2020 in the home's 2nd floor med cart. According to the manufacturer's instructions, the eye drop should be thrown away 28 days after opening.*

**Plan of Correction****Do Not Accept**

*Eye drops disposed of at time of inspection, new bottle in the cart. Nursing staff will be retrained on proper storage procedures. All medication will be dated and disposed of according to manufactures guidelines. Reference sheet will be created to address when medications should be discarded after opening. See attachment 6*

**Completion Date:** 03/11/2021

183e - Storing Medications (*continued*)**Update - 02/26/2021**

*How will the home ensure that compliance is maintained and that opened expired medications do not remain on the cart? Who will be responsible? How often will this be monitored and for what duration?*

**Plan of Correction****Accept**

*Eye drops disposed of at the time of inspection, a new bottle in the cart. Nursing staff will be retrained on proper storage procedures. All medication will be dated and disposed of according to manufacturers' guidelines. A reference sheet will be created to address when medications should be discarded after opening. The cart will be audited weekly on the 11-7 sheet and the audit sheet will be reviewed by the Wellness Director See attachment 6*

**Completion Date:** 03/12/2021

## 184a - Labeling OTC/CAM

**1. Requirements**

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

**Description of Violation**

*The pharmacy label for resident #5's Tramadol 50 mg says 4 times daily as needed but the order changed to once daily at 09:00 PM. A direction change sticker was not present on the card.*

**Plan of Correction****Do Not Accept**

*Nursing staff will be retrained on proper labeling of medications due to direction change by doctor and the use of direction change stickers. See attachment 6*

**Completion Date:** 03/11/2021

**Update - 02/26/2021**

*How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?*

**Plan of Correction****Accept**

*Nursing staff will be retrained on proper labeling of medications due to direction change by the doctor and the use of direction change stickers. Carts to be audited weekly by the 11-7 nurse and audit sheet reviewed by the Wellness Director weekly See attachment 6*

**Completion Date:** 03/12/2021

## 185b - Medication Procedures

**1. Requirements**

2600.

185.b. At a minimum, the procedures must include:

## 185b - Medication Procedures (continued)

**Description of Violation**

On 02/04/2021 at 09:18 AM, resident #6 was given her daily dose of Lorazepam Intensol 2 mg. This medication was not signed out on the resident's Controlled Substance Record.

The Controlled Substance Record for resident #7's Oxycodone 10 mg showed a remaining quantity of 48. The actual number of pills available at the time of the inspection was 47. The home was unable to explain the discrepancy.

**Plan of Correction****Do Not Accept**

Nursing staff coached and retrained on proper medication procedures. See attachment 6

Completion Date: 03/11/2021

**Update - 02/26/2021**

How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?

**Plan of Correction****Directed**

Nursing staff coached and retrained on proper medication procedures. MAR to be audited by the Wellness Director on a monthly basis for the next 6 months and then randomly thereafter. See attachment 6  
Licensee's Proposed Date for POC Implementation: 3/12/2021

Directed 3/1/2021 CM: Immediately, a narcotic count will be conducted by two staff persons daily on each shift. Documentation will be kept.

Within 30 days of receipt of the plan of correction: The administrator will review and update if necessary the home's procedures for the safe storage, access, security, distribution and use of medications, including the procedures for medication accountability. All staff persons qualified to administer medications will be reeducated on the home's policy and procedures. Documentation of education shall be kept.

The administrator will conduct a check of the home at least weekly to ensure the proper storage of medications including syringes.

Completion Date: 03/12/2021

## 187a - Medication Record

**1. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

**Description of Violation**

Resident #8 is prescribed Novolog insulin injection on a sliding scale: 200-250 requires 4 units, 251-300 6 units, 301-350 8 units, and 351-400 10 units. However, the resident's Jan 2021 medication administration record (MAR) does not indicate the units of insulin given.

## 187a - Medication Record (continued)

**Plan of Correction****Do Not Accept***EMAR adjusted to ask for the amount of insulin given See attachment 9***Completion Date:** 02/25/2021**Update - 02/26/2021***How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?***Plan of Correction****Directed***EMAR adjusted to ask for the amount of insulin given. Wellness director will observe compliance on monthly EMAR audit. Wellness Director will ensure all parameters for medications are documented upon admission and monthly See attachment 9**Licensee's Proposed Date for POC Implementation: 3/12/2021**Directed 3/1/2021 CM: Within 30 days of the receipt of the accepted plan of correction, all staff persons qualified to administer medications will be re-educated, by a certified medication administration Train-the-Trainer, on the required documentation of MARs in accordance with regulation 2600.187(a) including the proper documentation of prescription orders, medication dosage, and a purpose or diagnosis for each medication. Documentation of education shall be kept in the staff records.**A designated staff person qualified to administer medications will review all resident MARs and prescription orders at least weekly for the first three months, then monthly thereafter, to ensure all prescribed medications are documented on the MARs including the medication dose and the purpose or diagnosis for each medication. Documentations of reviews will be kept.***Completion Date:** 03/12/2021

## 187b - Date/Time of Medication Admin.

**1. Requirements**

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

**Description of Violation***Resident #7 is prescribed Oxycodone 10 mg - take 1 tablet by mouth every 6 hours as needed - was signed out almost daily at 06:00 AM according to its sign-out sheet. The resident's Jan 2021 MAR does not include the initials of the staff person who administered it on 01/01, 02, 04, 05, 06, 07, 08, 12, 13, 14, 16, 20, 21, 22, 23, 25, 26, 27, and 28/2021.**Resident #9 is prescribed Morphine Sul 100/5 ml every 3 hours as needed. The resident's January 2021 MAR does not include the initials of the staff person who administered it on 01/05, 01/12 and 01/27/2021.***Plan of Correction****Do Not Accept***Policy reviewed with all nursing staff on proper medication procedures. Nursing staff on duty during the days in question coached and counseled. See attachment 6***Completion Date:** 03/11/2021**Update - 02/26/2021***How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?*

## 187b - Date/Time of Medication Admin. (continued)

**Plan of Correction****Directed**

*Policy reviewed with all nursing staff on proper medication procedures. Nursing staff on duty during the days in question coached and counseled. Wellness director will observe compliance on monthly EMAR audit. See attachment 6*

*Licensee's Proposed Date for POC Implementation: 3/12/2021*

*Directed 3/1/2021 CM: Immediately – The administrator or designee qualified to administer medications will complete an initial audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b).*

*Immediately: A designated staff person qualified to administer medications will review all resident MARs at least weekly to ensure the proper documentation of medication administration at the time of administration. Documentation of reviews will be kept.*

*Within 30 days of receipt of the accepted plan of correction: All staff persons qualified to administer medications will be re-educated on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of education shall be kept.*

**Completion Date:** 03/12/2021

## 201 - Positive Interventions

**1. Requirements**

2600.

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

**Description of Violation**

*On 02/29~03/01/2020 during the night shift, resident #1 wandered the hallways, screaming, yelling, and banging on other residents' doors. The staff on duty failed to implement positive interventions to redirect or de-escalate the situation, and at one point, the resident started wielding a metal rod in front of the care manager. The resident was found with bruises and wounds on her left arm next day.*

**Plan of Correction****Do Not Accept**

*Staff in serviced and trained on positive interventions and de-escalation techniques. Care manager in question was suspended immediately and was later terminated. See attachment 7*

**Completion Date:** 03/11/2021

**Update - 02/26/2021**

*How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?*

201 - Positive Interventions (*continued*)**Plan of Correction****Directed**

*Staff in serviced and trained on positive interventions and de-escalation techniques. Care manager in question was suspended immediately and was later terminated. Staff will receive de-escalation by the wellness director upon hire and as needed when behaviors are noted. See attachment 7*

*Licensee's Proposed Date for POC Implementation: 3/12/2021*

*Directed 3/1/2021 CM: Immediately: The administrator or designee will monitor the care and services of for residents whom require mental health or behavioral care and services for at least two residents a week for three months and biannually thereafter to ensure the residents are receiving the care and services indicated in the resident's support plans and the use of positive interventions is implemented. Documentation of monitoring shall be kept.*

**Completion Date:** 03/12/2021

## 224a - Preadmission Screen Form

**1. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

**Description of Violation**

*Resident #10's preadmission screening form, dated 11/22/2020, does not include a determination that the needs of the resident can be met by the services provided by the home.*

**Plan of Correction****Do Not Accept**

*Screening repaired at the time of inspection. Going forward admission paperwork with be screened by a second person.*

**Completion Date:** 02/25/2021

**Update - 02/26/2021**

*Have all records been audited to ensure that there are no existing discrepancies? How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?*

**Plan of Correction****Accept**

*Screening repaired at the time of inspection. Going forward admission paperwork with be screened by a second person. As of 2/26/2021 all records have been audited by the wellness director for compliance. Wellness Director and Executive Director will audit all new admission charts for compliance on going.*

**Completion Date:** 02/26/2021

## 225c - Additional Assessment

**1. 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.

225c - Additional Assessment (*continued*)**Description of Repeat Violation**

*Resident #1's most recent assessment was completed on 04/14/2020. However, the condition of the resident changed significantly around November 2019, when the resident developed behavioral issues including aggressive episodes.*

*Repeated Violation: 8/26/2020*

**Plan of Correction****Do Not Accept**

*Nursing staff has been educated and in serviced on updating the RASP as incidents occur. All remaining resident's charts have also been audited for updating and a compliance tickler is being utilized for regular monitoring and compliance. Resident in question was evaluated and assessed as needing a higher level of care and was moved into the secured memory care neighborhood. See attachment 8*

**Completion Date:** 03/11/2021

**Update - 02/26/2021**

*How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?*

**Plan of Correction****Accept**

*Nursing staff has been educated and in serviced on updating the RASP as incidents occur. All remaining resident's charts have also been audited for updating and a compliance tickler is being utilized for regular monitoring and compliance. Resident in question was evaluated and assessed as needing a higher level of care and was moved into the secured memory care neighborhood. Per the attachment records will be monitored monthly for changes in condition. See attachment 8*

**Completion Date:** 02/26/2021

## 251b - Record Entries Legible

**1. Requirements**

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

**Description of Violation**

*On the Controlled Substance Record for resident #7's Oxycodone 10mg, all fields of the 2nd line of entry are scratched out without proper notation. On the entry for 1/9/21, part of the date and the amount on hand are written over, and the amount received and the amount given are crossed off without proper notation. On the entry just below, labeled as 11/10/21, the amount received field is crossed out without proper notation.*

**Plan of Correction****Do Not Accept**

*Staff trained on the importance of writing legibly. See attachment 6*

**Completion Date:** 03/11/2021

**Update - 02/26/2021**

*How will the home ensure that compliance is maintained? Who will be responsible? How often will this be monitored and for what duration?*

251b - Record Entries Legible *(continued)***Plan of Correction****Accept**

*Staff trained on the importance of writing legibly. written records will be monitored by the wellness director weekly for the next 3 months than monthly going forward for compliance. See attachment 6*

**Completion Date:** 03/12/2021

**DEPARTMENT OF HUMAN SERVICES  
RECOMMENDATION FOR CERTIFICATE OF COMPLIANCE**

REGION S <input checked="" type="checkbox"/> N <input type="checkbox"/> C <input type="checkbox"/> W <input type="checkbox"/>			COUNTY Montgomery		
NAME OF LEGAL ENTITY AB East Norriton Operator			TELEPHONE NO. OF LEGAL ENTITY 856-813-2000		
MAILING ADDRESS OF LEGAL ENTITY 525 Fellowship Road, Suite 360 Mount Laurel, NJ 08054					
NAME OF AGENCY/FACILITY Brandywine Senior Living at Senior Suites			TELEPHONE NO. OF FACILITY		
ADDRESS OF FACILITY 2101 New Hope Street, East Norriton, PA 19401					
TYPE OF CERTIFICATE <input type="checkbox"/> New <input type="checkbox"/> Renewal <input checked="" type="checkbox"/> Revision		EFFECTIVE DATE (CURRENT CERT.)		IF PRIVATE <input checked="" type="checkbox"/> Profit <input type="checkbox"/> Non-Profit	
CERTIFICATE NUMBER 144250	LICENSED CAPACITY 245/ 40 SDCU	CURRENT CENSUS 61/ 17 SDCU	TYPE OF CONTROL <input type="checkbox"/> Public <input checked="" type="checkbox"/> Private		

TYPE OF FACILITY AND TYPE OF SERVICE PROVIDED:	
REGULATION CHAPTER AND SERVICE TYPE 2600 - Personal Care Homes	POPULATION SERVED (INDICATE TYPE: Child, Adult, Geriatric, etc.) (PCH-#SSI,#60+,#MH,#ID,#MN) 0 SSI, 60 60+, 0 MH, 0 ID, 31 MN
DATES OF INSPECTION 2/3/2021, 2/4/2021	BEO APPROVAL DATE


RECOMMENDATIONS			
<input checked="" type="checkbox"/> CERTIFICATE RECOMMENDED	TYPE <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Provisional	IF PROVISIONAL <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Fourth	
		SCORE	PERIOD FROM <b>3/4/2021</b> TO <b>5/31/2021</b>
<input type="checkbox"/> NEGATIVE SANCTION	REASON <input type="checkbox"/> Denial <input type="checkbox"/> Non-Renewal <input type="checkbox"/> Revocation <input type="checkbox"/> Voluntary Closure <input type="checkbox"/> Other	EFFECTIVE DATE OF ACTION	

BASIS FOR RECOMMENDATION	
Human Services Licensing Received  3/2/2021	

CERTIFICATE OF OCCUPANCY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	DATE 8/27/2003	ISSUING AUTHORITY/TYPE L & I / C-2 LP
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LIST ANY RESTRICTIONS TO CERTIFICATE OF COMPLIANCE (If required by program office) Secure Dementia Care Unit - 55 Pa Code §§ 2600.231-239 - Capacity 40
--

REVISION OF EXISTING CERTIFICATE OF COMPLIANCE			
ITEM (address, capacity, legal entity, other)	CURRENT	NEW	EFFECTIVE DATE OF CHANGE
Change in Capacity - SDCU	40	50	

SIGNATURE/DATE - STAFF MAKING RECOMMENDATION  3/1/2021	SIGNATURE/DATE - PROGRAM OFFICE APPROVAL Jill Kachmar 3/2/2021
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# RECOMMENDATION FOR CERTIFICATE OF COMPLIANCE (RENEWALS ONLY)

**INSTRUCTIONS:** Regional Program Office completes form, makes two copies, keeps one copy and forwards the original and one copy to the Licensing Office. (This form is to be used for RENEWALS ONLY.)

REGION <b>SOUTHEAST</b>		COUNTY <b>MONTGOMERY</b>	
NAME AND ADDRESS OF AGENCY/FACILITY <b>BRANDYWINE SENIOR LIVING AT SENIOR SUITES</b>		FACILITY E-MAIL <b>JGONZALEZ@BRAND</b>	
2101 NEW HOPE STREET.			
EAST NORRITON 19401			
MAILING ADDRESS OF FACILITY		LEGAL E-MAIL <b>JGONZALEZ@BRANDYCARE.COM</b>	
525 FELLOWSHIP ROAD, SUITE 360			
MOUNT LAUREL NJ 08054		TELEPHONE NO: <b>610-272-6200</b>	
NAME OF LEGAL ENTITY <b>AB EAST NORRITON OPERATOR LLC</b>		FEIN/SSN:	
CURRENT CERTIFICATE NUMBER ▶ <b>144250</b>	TYPE OF CONTROL ▶ <input type="checkbox"/> PUBLIC <input checked="" type="checkbox"/> PRIVATE		
EFFECTIVE DATE ▶ FROM <b>5/31/2021</b> TO <b>5/31/2022</b>	IF PRIVATE ▶ <input checked="" type="checkbox"/> PROFIT <input type="checkbox"/> NON-PROFIT		

<b>TYPE OF FACILITY &amp; TYPE OF SERVICE PROVIDED:</b>	
ADULT RESIDENTIAL FACILITIES PERSONAL CARE HOMES	Human Services Licensing Received  3/2/2021
DATE(S) OF INSPECTION ▶ <b>2/3/2021, 2/4/2021</b>	

<b>RECOMMENDATIONS:</b>			
<input checked="" type="checkbox"/> CERTIFICATE RECOMMENDED	TYPE <input checked="" type="checkbox"/> REGULAR <input type="checkbox"/> PROVISIONAL	IF PROVISIONAL <input type="checkbox"/> FIRST <input type="checkbox"/> SECOND <input type="checkbox"/> THIRD <input type="checkbox"/> FOURTH	
		SCORE	PERIOD FROM _____ TO _____
<input type="checkbox"/> CERTIFICATE NOT RECOMMENDED	REASON <input type="checkbox"/> DENIAL <input type="checkbox"/> NON-RENEWAL <input type="checkbox"/> REVOCATION <input type="checkbox"/> VOLUNTARY CLOSURE <input type="checkbox"/> OTHER		
LIST REGULATION CHAPTER <b>2600 - Personal Care Homes</b>		FIRE SAFETY APPROVAL ▶ <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
		DATE <b>8/27/2003</b>	TYPE <b>C-2 LP / L&amp;I</b>
		LICENSED CAPACITY <b>245/ 50 SDCU</b>	CURRENT CENSUS <b>61/ 17 SDCU - 0 SSL, 60 60+, 0 MH, 0 ID, 31 MN</b>
LIST ANY RESTRICTIONS TO OCCUPANCY OR WAIVERS OF REGULATION <b>Secure Dementia Care Unit - 55 Pa Code §§2600.231-239 - Capacity 50</b>			

 3/1/2021  
SIGNATURE -- PERSON MAKING RECOMMENDATION

APPROVED BY



**BRANDYWINE LIVING**

*Life is Beautiful*

June 24, 2019

**Human Services Licensing**

**JUN 25 2019**

Jill Kachmar  
Regulatory Licensing Manager  
Pennsylvania Department of Human Services  
Bureau of Human Services Licensing  
Health & Welfare Building (Room 631)  
625 Forster Street  
Harrisburg, Pennsylvania 17120

*RE: Brandywine Living at Senior Suites  
2101 New Hope Street  
East Norriton, Pennsylvania 19401*

Dear Ms. Kachmar:

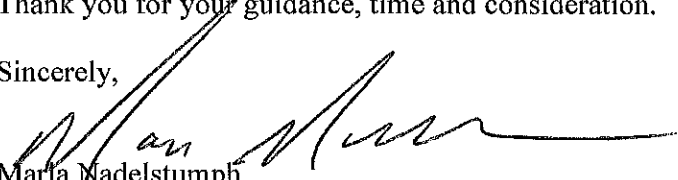
Please find a formal notification request for Brandywine Living at Senior Suites to increase the bed capacity from 40 to 50 beds in their existing secured dementia care unit (SDCU). The change is shifting existing personal care beds to SDCU beds on the same floor. There will be no change in the overall community capacity (245).

Enclosed is the requested information for your review. The documentation request (#13-2600.233(b)- statement from the manufacturer) is enclosed for the existing locking system on the SDCU. The letter for the added lock system will come under separate cover.

If you need any additional information, please reach out to me directly at [mnadelstumph@brandycare.com](mailto:mnadelstumph@brandycare.com) or 609-304-0173.

Thank you for your guidance, time and consideration.

Sincerely,

  
Marla Nadelstumph  
VP of Organizational Development & Program Excellence  
Brandywine Living

cc Jessica Gonzalez

525 FELLOWSHIP ROAD SUITE 360 MOUNT LAUREL *new jersey* 08054

*phone* 856.813.2000 *fax* 856.813.2020

WWW.BRANDYCARE.COM

**Commonwealth of Pennsylvania**  
**Department of Human Services**  
 Bureau of Human Services Licensing  
 Adult Resident Licensing  
 Policies and Procedures

**Notification to Department 2600.239 (a) 3**  
*(SDCU-increasing maximum capacity to an existing unit  
 40 beds to 50 beds-no change to capacity of home )*

**Personal Care Home: Brandywine Living at Senior Suites**

1.	<b>The home's certificate of occupancy</b>	See attached
2.	<b>Name, address and legal Entity of home</b>	Brandywine Living at Senior Suites 2101 New Hope Street East Norriton, PA 19401
3.	<b>Administrator Name</b>	AB East Norriton Operator, LLC Jessica Gonzalez
4.	<b>Maximum Capacity of Home</b>	245
5.	<b>Requested resident population of the secured dementia unit</b>	50 (current license capacity is 40)
6.	<b>Building description</b>	Three story personal care residence with resident rooms on 1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> floors. Ample common/activity/public spaces on each floor and 1 <sup>st</sup> floor main dining room. Secured SDCU on 3rd floor.
7.	<b>Unit Description</b>	The current operating unit is on a portion of the third floor and has 30 units. The request for expansion will encompass the entire third floor bringing the total unit count to 42. There are two activity spaces, a dining room, public restrooms, lounge, Wellness office, recreation office, laundry rooms, kitchen and supervised access to 1 <sup>st</sup> floor enclosed outdoor courtyard.
8.	<b>Type of Locking System</b>	Dortronics Systems, Inc. Field Programmable 7101-P EDR System 101

525 Fellowship Rd.  
 Suite 300  
 Mt Laurel, NJ  
 08054

9.	<b>Policy and Procedures to be implemented for emergency egress and resident elopement</b>	See attached
10.	<b>A sample 2-week staffing schedule</b>	See attached
11.	<b>Verification of completion of additional training requirements</b>	See attached
12.	<b>Operational Description of locking system</b>	There key code access to leave the unit via the elevator. All exit doors are equipped with mag locks and a 15 second egress.
13.	<b>The manufacturer's statement regarding the secured dementia care unit locking system</b>	See attached-Existing Locks on SDCU Under Separate Cover-Expansion Side
14.	<b>A written approval or a variance permitting the locked exit doors from the Department of Labor and Industry, the DOH or the appropriate local building authority.</b>	See attached-Existing Locks on SDCU Under Separate Cover-Expansion Side
15.	<b>Name of municipality or 24-hr monitoring service maintaining interconnection with the home's fire alarm system</b>	Rapid Response 400 W. Division Street Syracuse, NY 13204
16.	<b>A sample plan of care and service for the resident addressing the resident's physical, medical, social, cognitive, and safety needs for the residents.</b>	See attached
17.	<b>The activity standards</b>	See attached
18.	<b>The complete medical and cognitive preadmission assessment that is completed upon admission and reviewed and updated annually.</b>	See attached
19.	<b>A consent form agreeing to the resident's placement in the secured unit, to be signed by the resident or resident's designated person.</b>	See attached
20.	<b>A written agreement containing full disclosure of services, admission, and discharge criteria, change in condition policies, services, special programming, costs and fees.</b>	See attached
21.	<b>A description of environmental cues being utilized.</b>	The SDCU will have memory boxes outside of each resident room to personalize rooms and support wayfinding. Social spaces have appropriate signage and directional cues.
22.	<b>A general floor plan of the entire home</b>	See attached
23.	<b>A specific floor plan of the secured dementia care unit, outside enclosed area and exercise space.</b>	See attached