



**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE: November 2, 2022**

[REDACTED]  
[REDACTED]  
AB East Norriton Operator, LLC  
[REDACTED]  
[REDACTED]

RE: Brandywine Senior Living at Senior Suites  
2101 New Hope Street  
East Norriton, Pennsylvania 19401  
License #: 144251

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection February 28, 2022, March 30, 2022, April 20, 21, 27, and 28, 2022, June 1, 16, and 17, 2022, and July 15, 2022 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 144250 dated May 31, 2022 to May 31, 2023 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated May 31, 2022 to May 31, 2023 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(1) ;(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from November 2, 2022 to May 2, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.


| 55 Pa. Code Chapter 2600 or 2800 Section: | Class of Violation | Census at Inspection | Fine Per Resident X Per day | Calculated Fine = Per Day | Mandated Correction Date (to avoid Fine)         |
|---|--------------------|----------------------|-----------------------------|---------------------------|--|
| 187(a)                                    | II                 | 89                   | \$5                         | \$445                     | 5 calendar days from mailing date of this letter |

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

  
 Pennsylvania Department of Human Services  
 Bureau of Human Services Licensing  
 Room 631, Health and Welfare Building  
 625 Forster Street  
 Harrisburg, Pennsylvania 17120  
 PH: 717-214-1304

[REDACTED]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

*Jamie F. Buchenauer*

Jamie Buchenauer  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Licensing Inspection Summary

cc:

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

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

**Facility Information**

Name: *BRANDYWINE SENIOR LIVING AT SENIOR SUITES* License #: *14425* License Expiration: *05/31/2023*  
Address: *2101 NEW HOPE STREET, EAST NORRITON, PA 19401*  
County: *MONTGOMERY* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *AB EAST NORRITON OPERATOR LLC*

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

**Staffing Hours**

Resident Support Staff: Total Daily Staff: *123* Waking Staff: *92*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Interim* Exit Conference Date: *07/15/2022*

**Inspection Dates and Department Representative**

07/15/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *245* Residents Served: *89*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Memory Care* Capacity: *50* Residents Served: *30*

**Hospice**

Current Residents: *12*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *89*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *34* Have Physical Disability: *2*

**Inspections / Reviews**

**07/15/2022 - Partial**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/15/2022*

**08/18/2022 - POC Submission**

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/22/2022*

Inspections / Reviews *(continued)*

10/12/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

Follow-Up Date:

183d - Prescription Current

1. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 7/15/22, Ipratropium Bromide prescribed for Resident #3, was in the home's medication cart; however, the medication was discontinued.

Plan of Correction

Accept

Upon discovery the Ipratropium Bromide was removed by the Wellness Director from the medication cart. The order had been previously discontinued, however the drug was not removed. It was not documented as administered since it was discontinued on 5/19/22.

On 7/25/22 all nurses were in-serviced on Regulation 183.d. relating to only current prescriptions being present in the medication cart.

The Wellness Nurse, Wellness Director or designee will audit for the correct medications being present for all residents in relation to the MAR on a weekly basis for the next three months. See attached audit form.

POC to be reviewed at Quarterly Quality Improvement Meeting.

Completion Date: 7/25/22, weekly for 3 months and quarterly.

08-19-2022

Not Implemented

Completion Date: Licensee's Proposed Date for POC Implementation 07-25-22

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:

Description of Violation

Resident #2 is prescribed Novolog Aspart Flexpen, inject designated units subcutaneously based on sliding scale: 151-200= 2 units, 201-250= 3 units, 251-300= 4 units, greater than 300= 5 units . This medication was administered on 7/11/22 at 11:40 am and at 12:42 pm, and on 7/1/22 at 4:54 pm and 3:44 pm; however, it is not included on resident #2's medication administration record.

Repeat violation et al 02-03-2021

Plan of Correction

Accept

Upon discovery the Wellness Director audited all resident's MARs with sliding scale insulin to ensure that the ability to record the insulin dosage at the time of administration was present. This was found present for all resident's with sliding scale insulin except Resident #2 and Resident #5. This was immediately added to the MAR of Resident #2 and Resident #5.

On 7/25/22 all nurses were in-serviced on Regulation 187.a. relating to requirements of the medication administration record.

## 187a - Medication Record (continued)

The Wellness Nurse, Wellness Director or designee will audit for the correct dates, readings, medication and information in relation to the MAR on a weekly basis for the next three months. See attached audit form.

POC to be reviewed at Quarterly Quality Improvement Meeting.

Completion Date: 7/25/22, weekly for 3 months and quarterly.

Completion Date: Licensee's Proposed Date for POC Implementation 07-25-22

■ 08-19-2022  
Not Implemented

## 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 #1 is prescribed Morphine Sulfate 20 MG, give 0.25 ml in mouth or under the tongue every 1 hour as needed for pain. On 7/15/22, Staff person A initialed the medication administration record as administered at 10:30 am. The medication was not administered until 12:30 pm.

Resident #2 is prescribed Novolog Aspart Flexpen, inject designated units subcutaneously based on sliding scale: 151-200= 2 units, 201-250= 3 units, 251-300= 4 units, greater than 300= 5 units. This medication was administered on 7/11/22 at 11:40 am and at 12:42 pm, and on 7/1/22 at 4:54 pm and 3:44 pm; however, staff person A recorded the medication was not passed on the medication administration record.

**Plan of Correction**

Upon discovery the Executive Director prepared incident reports to be filed for the above medication errors for both Resident #1 and Resident #2. These were filed with the Department on 7/16/22.

The Wellness Nurse Staff Person #1 for Resident #1 was immediately addressed via performance counseling regarding the delay in the resident receiving his PRN pain medication. This was also addressed in a in-service with all Wellness Nurses on regulation 187.b. and regulation 42.b.

The Wellness Director audited all of resident #2's MARs to ensure that the ability to record the insulin dosage at the time of administration was present. This was found present for all resident's with sliding scale insulin except Resident #2 who had a recent change to ■ order. This order was discontinued on 7/9/2022 due to ■ hospice status.

On 7/25/22 all nurses were in-serviced on Regulation 187.b. relating to requirements of recording time on the medication administration record.

The Wellness Nurse, Wellness Director or designee will audit for the correct dates, readings, medication and information in relation to the MAR for standing and PRN orders on a weekly basis for the next three months. See attached audit form.

POC to be reviewed at Quarterly Quality Improvement Meeting.

Completion Date: 7/25/22, weekly for 3 months and quarterly.

**Accept**

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

08-19-2022  
Not Implemented

Completion Date: Licensee's Proposed Date for POC Implementation 07-25-22

188b - Medication Error

1. Requirements

Reporting  
2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 is prescribed Novolog Flexpen, inject 4 times per day per sliding scale order. Blood sugar readings are being taken in the evening, however insulin is not being administered for the evening readings. The medication error was not reported to the resident, the resident's designated person and the prescriber.

Resident #2 is prescribed Novolog Aspart Flexpen, inject designated units subcutaneously based on sliding scale: 151-200= 2 units, 201-250= 3 units, 251-300= 4 units, greater than 300= 5 units . On 7/10/22, the resident's blood glucose was 312. Resident #2 was administered 4 units. Per sliding scale, the resident should have been administered 5 units. The medication error was not reported to the resident, the resident's designated person and the prescriber.

Plan of Correction

Accept

Upon discovery the Executive Director prepared incident reports to be filed for the above medication errors for both Resident #1 and Resident #2. These were filed with the Department on 7/16/22.

On 7/25/22 all nurses were in-serviced on Regulation 188.b. and 16.c. relating to requirements of the medication error reporting and incident reporting requirements.

On 7/27/22 all team members were in-serviced on Regulation 16.c. in relation to incident reporting requirements.

The Wellness Nurse, Wellness Director or designee will audit for the correct dates, readings, medication and information in relation to the MAR for standing and PRN orders on a weekly basis for the next three months. See attached audit form. Any medication errors discovered will be immediately reported to the department.

POC to be reviewed at Quarterly Quality Improvement Meeting.  
Completion Date: 7/27/22, weekly for 3 months and quarterly.

08-19-2022  
Not Implemented

Completion Date: Licensee's Proposed Date for POC Implementation 07-27-22

16c - Written Incident

1. Requirements

Report  
2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

16c - Written Incident Report (continued)

Description of Violation

Resident #1 is prescribed Novolog Flexpen, inject 4 times per day per sliding scale order. Blood sugar readings are being taken in the evening, however insulin is not being administered for the evening readings. The home did not report this medication error to the department.

On 7/10/22, Resident #2 was administered 4 units of Novolog Aspart Flexpen. Per the resident's sliding scale order, the resident should have been administered 5 units. The home did not report this medication error to the department.

Plan of Correction

Accept

Upon discovery the Executive Director prepared incident reports to be filed for the above medication errors for both Resident #1 and Resident #2. These were filed with the Department on 7/16/22.

On 7/25/22 all nurses were in-serviced on Regulation 188.b. and 16.c. relating to requirements of the medication error reporting and incident reporting requirements.

On 7/27/22 all team members were in-serviced on Regulation 16.c. in relation to incident reporting requirements.

Training on Incident Reporting Requirements will continue Quarterly for 1 year by ED or designee.

POC to be reviewed at Quarterly Quality Improvement Meeting.

Completion Date: 7/27/22, quarterly for one year.

08-19-2022

Completion Date: Licensee's Proposed Date for POC Implementation 07-25-22

Not Implemented

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1 is prescribed Morphine Sulfate 20 MG, give 0.25 ml by mouth or under the tongue every 1 hour as needed for pain. While conducting an audit of the resident's controlled substances on 7/15/22 at 12:30 pm, it was determined that the narcotic count sheet read there should be 28 syringes of Morphine, however 29 syringes were present. The medication was signed off as administered on 7/15/22 at 10:30 am. Staff person A admitted to signing off as having administered the medication and updating the narcotic count sheet, but forgot to give the resident the medication as requested.

The medication is needed prior to providing wound care treatment because the resident experiences pain during treatment.. The medication was administered 2 hours later.

Plan of Correction

Accept

Upon discovery the Executive Director prepared incident reports to be filed for the above incident for Resident #1. This was filed with the Department on 7/16/22.

**42b - Abuse (continued)**

*The Wellness Nurse, Staff Person #1, for Resident #1 was immediately addressed via performance counseling regarding the delay in the resident receiving his PRN pain medication. This was also addressed in an in-service with all Wellness Nurses on regulation 187.b., 16.c. and regulation 42.b..*

*On 7/27/22 all staff were in-serviced on Regulation 16.c and regulation 42.b. relating to the requirements of incident reporting and resident's rights. These training will continue quarterly for all staff for one year.*

*POC to be reviewed at Quarterly Quality Improvement Meeting.  
Completion Date: 7/27/22 and quarterly for one year.*

08-19-2022  
Not Implemented

**Completion Date:** Licensee's Proposed Date for POC Implementation 07-27-22

**185a - Implement Storage****1. Requirements****Procedures**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

**Description of Violation**

*On 7/15/22 at 12:30 pm, the narcotic count sheet for Resident #1's Morphine Sulfate read there should be 28 syringes, however 29 syringes were present. One syringe was signed out as administered on 7/15/22 at 10:30 pm but had not been administered.*

*On 7/5/22 at 9:51 am, Resident #2's glucometer reads "HI", the resident's Medication Administration Record (MAR) has a blood sugar reading recorded as 412.*

*On 7/1/22 at 4:54 pm and 3:44 pm, Resident #2's glucometer reads "HI", this is not record on the resident's MAR.*

*On 7/8/22 at 9:28 pm, Resident #4's glucometer reads 186, the resident's MAR has a blood sugar reading recorded as 198.*

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

*On 7/27/22 all Wellness Nurses were in-serviced on Regulation 185.a. relating to the requirements of medication storage.*

*The Wellness Nurse, Wellness Director or designee will audit for the medication storage, correct dates, readings, medication and information in relation to the MAR for standing and PRN orders on a weekly basis for the next three months. See attached audit form.*

## 185a - Implement Storage Procedures (continued)

POC to be reviewed at Quarterly Quality Improvement Meeting.  
 Completion Date: 7/27/22 and quarterly for one year.

08-19-2022

Not Implemented

Completion Date: Licensee's Proposed Date for POC Implementation 07-25-22

## 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:

**Description of Violation**

Resident #5 is prescribed Humalog Kwik Inj 100/ML per Sliding Scale inject 4 times daily (200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, <70 or >400 call MD). On, 7/12/22 at 8:39 pm blood sugar read 243. However, the resident's medication administration record does not indicate units were administered on the following dates and times:

- On 7/12/22 at 8:39 pm blood sugar read 243
- On 7/13/22 at 8:52 pm blood sugar read 207
- On 7/14/22 at 1:55 pm blood sugar read 315
- On 7/14/22 at 10:59 pm blood sugar read 216

Repeat Violation: 2/3/21 et al.

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

Upon discovery the Wellness Director audited all resident's MARs with sliding scale insulin to ensure that the ability to record the insulin dosage at the time of administration was present. This was found present for all resident's with sliding scale insulin except Resident #2 and Resident #5. This was immediately added to the MAR of Resident #2 and Resident #5.

On 7/25/22 all nurses were in-serviced on Regulation 187.a. relating to requirements of the medication administration record.

The Wellness Nurse, Wellness Director or designee will audit for the correct dates, readings, medication and information in relation to the MAR on a weekly basis for the next three months. See attached audit form.

POC to be reviewed at Quarterly Quality Improvement Meeting.  
 Completion Date: 7/25/22, weekly for 3 months and quarterly.

08-19-2022

Not Implemented

Completion Date: Licensee's Proposed Date for POC Implementation 07-25-22

## 187d - Follow Prescriber's Orders

## 1. Requirements

2600.

187.d. The home shall follow the directions of the prescriber.

187d - Follow Prescriber's Orders (*continued*)**Description of Violation**

*Resident #1 is prescribed Novolog Flexpen, inject 4 times per day per sliding scale order. Blood sugar readings are being taken in the evening, however insulin is not being administered for the evening readings.*

*Resident #2 is prescribed Novolog Aspart Flexpen, inject designated units subcutaneously based on sliding scale: 151-200= 2 units, 201-250= 3 units, 251-300= 4 units, greater than 300= 5 units . On 7/10/22, the resident's blood glucose was 312. Resident #2 was administered 4 units. Per sliding scale, the resident should have been administered 5 units.*

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

*On 7/25/22 all Wellness Nurses were in-serviced on Regulation 185.d. relating to the requirements of following the directions of the prescriber.*

*The Wellness Nurse, Wellness Director or designee will audit for the medication storage, correct dates, readings, medication and information in relation to the MAR for standing and PRN orders on a weekly basis for the next three months. See attached audit form.*

*POC to be reviewed at Quarterly Quality Improvement Meeting.*

*Completion Date: 7/25/22 and quarterly for one year.*

**Completion Date:** Licensee's Proposed Date for POC Implementation 07-25-22

■ 08-19-2022

Not Implemented