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

January 9, 2025

WELL BL OPCO LLC

ATTN BRENDA BACON

RE: BRANDYWINE LIVING AT LONGWOOD
301 VICTORIA GARDENS DRIVE
KENNETT SQUARE, PA, 19348
LICENSE/COC#: 14430

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/20/2024, 11/21/2024, 11/22/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BRANDYWINE LIVING AT LONGWOOD* **License #**: *14430* **License Expiration**: *07/19/2025*

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

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *WELL BL OPCO LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *06/10/2009* **Issued By**: *Kennett Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *91* **Waking Staff**: *68*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *11/21/2024*

Inspection Dates and Department Representative

11/20/2024 - On-Site:
11/21/2024 - On-Site:
11/22/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *61*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *23* **Residents Served**: *21*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *61*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

11/20/2024 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/21/2024*

Inspections / Reviews *(continued)*

01/09/2025 POC Submission

Submitted By: [redacted]
Reviewer: [redacted]
Date Submitted: *01/09/2025*
Follow Up Type: *Bypass Document Submission*

01/09/2025 Bypass Document Submission

Submitted By: [redacted]
Reviewer: [redacted]
Date Submitted: *01/09/2025*
Follow Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On at 9:13 pm, a nurse's note documented an incident involving Resident A care manager found Resident standing in Resident room with their pants unbuckled and unzipped. The care manager asked them firmly to leave the room and informed Staff Person A of the resident's behavior. As stated by multiple staff persons, resident frequently expresses inappropriate behaviors, including groping, pulling at clothing, and comments towards others, mostly towards staff, but occasionally towards other residents. Staff of the home reported that these behaviors began as early as two days after resident admission on , and the incidents involving staff were reported to the home. The care manager who witnessed Resident in Resident room, reported the incident to the home due to the resident's history of inappropriate behaviors however, the allegation of suspected abuse was not reported to the local Area Agency on Aging.

Plan of Correction ***Accept - 01/09/2025)***

Resident admitted to the community on During transition to the community and prior to the 11/11/24 incident, resident experienced difficulty sleeping and was suspected of having a UTI. An order for UA C&S was ordered on 11/10/24. Nursing notes to this effect are attached as well as a doctor's order for melatonin to treat difficulty sleeping and antibiotic to treat the UTI. Resident wandered into Resident room due to door always being open. Resident did not feel it was inappropriate and only called for assistance in order to get Resident back to room.

Training with staff to review the requirements of reporting under this regulation was completed on 11/21/24, 11/26/24 and 12/17/24 (see attached training records).

Training with staff will take place monthly through 2025 to ensure staff are aware of the requirements of reporting suspected or known abuse under this regulation. The Executive Director (or Designee) will be responsible.

Beginning January 2025, a monthly review of the plan of correction for 15a will take place as part of QI. The Executive Director (or Designee) will be responsible.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented - 01/09/2025)

16c - Written Incident Report

2. Requirements

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).

Description of Violation

On at 9:13 pm, a nurse's note documented an incident involving Resident A care manager found Resident standing in Resident room with their pants unbuckled and unzipped. The care manager asked them firmly to

16c Written Incident Report (continued)

leave the room and informed Staff Person A of the resident's behavior. As stated by multiple staff persons, resident frequently expresses inappropriate behaviors, including groping, pulling at clothing, and comments towards others, mostly towards staff, but occasionally towards other residents. Staff of the home reported that these behaviors began as early as two days after resident admission on and the incidents involving staff were reported to the home. The care manager who witnessed Resident in Resident room, reported the incident to the home due to the resident's history of inappropriate behaviors however, the allegation of suspected abuse was not reported to the Department.

Plan of Correction ***Accept - 01/09/2025)***

Resident admitted to the community on . During transition to the community, experienced difficulty sleeping and was diagnosed with a UTI. Nursing notes to this effect are attached as well as a doctor's order for melatonin to treat difficulty sleeping and antibiotic to treat the UTI. There were no instances of inappropriate sexual behaviors towards other residents and there was no suspicion of abuse towards other residents.

Training with staff to review the requirements of reporting under this regulation was completed on 11/21/24 ,11/26/24 and 12/17/24 (see attached training records).

Training with staff will take place monthly throughout 2025 to ensure staff are aware of the requirements of reporting suspected or known abuse to the Department's personal care home regional office or complaint hotline within 24 hours under this regulation. The Executive Director (or Designee) will be responsible.

Beginning January 2025, a monthly review of the plan of correction for 16c will take place as part of QI. The Executive Director (or Designee) will be responsible.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented - 01/09/2025)

18 - Compliance With Laws

3. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Influenza Awareness Act (NH 1785) requires that Personal Care Homes must post the required influenza information in a public place in the home year round. On , an awareness poster was not present in the home.

Plan of Correction ***Accept - 01/09/2025)***

An Influenza Awareness Poster was present in the home's 1st floor back elevator at the time of the survey. Additional posters were present in the home prior, but during recent renovations they were moved.

Influenza Awareness Posters were placed in 5 public places in the home and completed on 11/20/24 (see attached photos).

18 Compliance With Laws (continued)

Beginning January 2025, a monthly review of the plan of correction for 18 will take place as part of QI. The Executive Director (or Designee) will be responsible.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented (- 01/09/2025)

25b - Contract Signatures

4. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract, dated , for Resident was not signed by the resident.

Plan of Correction ***Accept (- 01/09/2025)***

The resident home contract dated for Resident was signed by the resident on (see attached).

All resident home contracts have been audited to ensure residents have signed their contract. Training to review the requirements under this regulation 25b regarding required signatures on the resident home contract was completed with the Community Sales Director on 11/26/24 (see attached training).

Beginning January 2025, a review of the requirements under this regulation 25b to ensure all resident home contracts are signed for all new Admissions to the home will take place as part of monthly QI. The Community Relations Director (or Designee) will be responsible.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented (- 01/09/2025)

66b - Training Plan Content

5. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

Description of Violation

The home's staff training plan does not include the dates and times of the scheduled training for each staff person.

Plan of Correction ***Accept (01/09/2025)***

The 2024 Staff Training Plan was changed to a Relias platform and staff received modules individually.

The 2025 Staff Training Plan has been established, including dates and times of the scheduled training for each staff person (see attached 2025 training plan).

66b - Training Plan Content (continued)

Training plan will be reviewed monthly to ensure trainings are being completed as scheduled and will be updated as needed throughout the year with dates and times. This audit will be presented in the monthly QI meeting. The Executive Director or Designee will be responsible.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented - 01/09/2025)

81b - Resident Personal Equipment

6. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On a covered bedside mobility device was present on Resident s bed. However, the enabler slid under the bed and was not securely attached to the structure of the bed. The bedside mobility device was observed to move away from the bed/mattress creating entrapment zones, posing a potential hazard to the resident.

Plan of Correction ***Accept (- 01/09/2025)***

An audit of all resident rooms was completed to identify all resident's using bedside mobility devices. All bedside mobility devices have been checked to ensure they are securely attached to the structure of the bed.

Staff has been in-serviced on 11/21/24, 11/26/24 and 12/17/24 as to the requirements under this regulation 81b and the process by which care managers will be responsible to report any new bedside mobility devices to the Wellness Director/or Assistant Wellness Director for any resident on their assignment during the shift in which it is observed (see attached training). The Wellness Director/or Assistant Wellness Director will check the device to ensure it is securely attached and meets all requirements under this regulation.

The Executive Director (or Designee) will be responsible to review this process and requirements under this regulation 81b at monthly Town Hall Meetings.

Bedside devices will be checked weekly by the Environmental Services Director or Designee when room is scheduled for cleaning. An audit will be completed and presented in the monthly QI meeting to ensure it is in good repair and free of hazards.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented - 01/09/2025)

105f - Labeling/Return of Clothes

7. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

105f - Labeling/Return of Clothes *(continued)*

Description of Violation

The home does not have a system to safeguard resident laundry from loss. On 11/20/24 residents' clothes were piled on top of a washer in the second-floor personal care laundry room. An unlabeled laundry basket with clothes was also placed on top of a washer in the second-floor memory care laundry room. The clothes were not labeled with names or room numbers.

Plan of Correction ***Accept (- 01/09/2025)***

Resident laundry baskets have been tagged with name and room number. A system by which room number is identified on washers and dryers during the laundering process has also been devised and is in place.

If a laundry basket is missing an identifying tag with the resident's name and room number, the care manager completing the resident's laundry will notify the Wellness Director, the Assistant Wellness Director, the Executive Director or Designee during the shift in which it is observed so that a tag can be re-issued for identification.

Staff were in-serviced on the new system for identifying resident laundry and related procedures on 11/21/24, 11/26/24 and 12/17/24 (see attached training). The Executive Director (or Designee) will be responsible to review this requirement in monthly Town Hall Meetings beginning January 2025.

The Environmental Services Director or Designee will be responsible to complete a weekly audit of all laundry facilities and present findings in the monthly QI meeting beginning January 2025.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented 01/09/2025)

171b4 - Staff Training

8. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff person B started to work as a chauffeur effective to transport residents. However, Staff person B has not completed the initial direct care staff training, and as stated by staff person B, no direct care trained staff persons accompany residents on trips when staff person B drives.

Plan of Correction ***Accept 01/09/2025)***

Staff Person B was hired as a Maintenance Assistant. later transferred in September 2023 to position of Chauffeur. The initial direct care staff training was not completed at the time of this internal position change but has now been completed as of 12/4/24 (see attached).

Effective 11/21/24 all chauffeurs will be required to complete the initial direct care staff training as part of the general orientation process.

171b4 - Staff Training (continued)

The Business Office Manager, HR Manager or Designee will be responsible to ensure direct care staff training for all staff who provide transportation to residents is completed upon hire. This will be presented for review during monthly QI beginning January 2025.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented [redacted] - 01/09/2025)

183e - Storing Medications

9. 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 [redacted], Resident [redacted] was punctured over number 9 and was covered with tape, which is an improper method of storage for medications.

Plan of Correction ***Accept ([redacted] - 01/09/2025)***

Resident [redacted] [redacted] was corrected to proper storage requirements under this regulation on [redacted].

Nursing staff was in-serviced 11/21/24 and 11/26/24 as to the proper method of storing medications under this regulation (see attached training).

Carts are being audited weekly by a Nurse effective 12/23/24. The Wellness Director will be responsible to ensure weekly cart audits are completed. Additionally, carts will be audited quarterly by the community's Pharmacy Service beginning Quarter 1 to ensure compliance to this regulation.

The Wellness Director (or Designee) will be responsible to review the weekly med cart audit to ensure compliance to the requirements of this regulation in the monthly QI meeting beginning January 2025 (see attached audit form).

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented [redacted] - 01/09/2025)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

184a Resident's Meds Labeled *(continued)*

Description of Violation

On , Resident was observed in the medication cart with no other packaging and there was no label or writing on the pen identifying the resident to which the pen belonged.

Plan of Correction ***Accept - 01/09/2025)***

Resident was marked to identify the resident to which the pen belonged at time of survey.

Resident's will be marked by the nurse who receives in the pen at time of medication delivery. Nursing staff were in serviced 11/21/24 and 11/26/24 on this procedure (see attached training).

Lantis Insulin Pens will be checked for compliance to the requirements of this regulation 184a during the weekly cart audits performed by nurses to begin 12/23/24 (see attached med cart audit form). The Wellness Director (or Designee) will be responsible to review the audit form at the monthly QI meeting beginning January 2025.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented - 01/09/2025)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

On , a care manager found Resident in Resident room with their pants unbuckled and unzipped. As stated by staff persons in the home, beginning approximately two days after residents admission, Resident frequently requested assistance from staff by claiming to be confused, which then often lead to incidents of inappropriate physical contact and comments made towards staff. Multiple incidents related to Resident inappropriate behaviors were witnessed by staff and reported to the home. Despite these incidents, no additional assessment was completed addressing the exhibited behaviors or supports to be implemented. Resident had an initial assessment completed on 10/12/24 and then an assessment due to a status change on 11/13/24 however, this updated assessment only addressed a change in the residents ability to self administer medications, with no changes to resident behavioral needs.

Plan of Correction ***Accept - 01/09/2025)***

Resident assessment has been updated to include behavioral needs and supports to be implemented (see attached care plan).

The Wellness Director and Assistant Wellness Director were in serviced on 11/26/24 as to the requirements under regulation 225c specific to updating assessments and address exhibited behaviors and supports to be implemented (see attached training).

225c - Additional Assessment (continued)

The Wellness Director or Designee will be responsible for completing an audit and reviewing it in the monthly QI meeting beginning January 2025 to ensure behavioral needs and supports are addressed in updated assessments and support plans.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented (- 01/09/2025)

227d - Support Plan Medical/Dental

13. Requirements

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

On , a bedside mobility device was present on Resident bed for turning and repositioning. Resident's assessment and support plan, dated does not indicate the resident's need for such a device and how this need will be addressed.

On , a bedside mobility device was present on Resident bed for turning and repositioning. Resident's assessment and support plan, dated does not indicate the resident's need for such a device and how this need will be addressed.

Plan of Correction ***Accept - 01/09/2025)***

The assessment and support plan for Resident has been updated with the resident's need for a bedside mobility device and how the need will be addressed (see attached care plan). Resident has since passed away from the date of survey.

The Wellness Director and Assistant Wellness Director were in-serviced on 11/26/24 as to the requirements under regulation 227d specific to updating assessments and support plans to address the need for a bedside mobility device and how this need will be addressed (see attached training record).

The Wellness Director or Designee will complete an audit and present it during the monthly QI meeting to ensure assessments and support plans reflect any new bedside devices and address the need for such a device.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented - 01/09/2025)

227g -Support Plan Signatures

14. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g Support Plan Signatures *(continued)*

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Plan of Correction ***Accept [redacted] - 01/09/2025)***

Resident [redacted] has a diagnosis of [redacted] and did not participate in the assessment and refused to sign the support plan. The support plan was updated to reflect this.

The Wellness Director and Assistant Wellness Director were in serviced on 11/26/24 as to the requirements under regulation 227g specific to residents who participate in the development of the support plan shall sign and date the support plan (see attached training record).

An audit of all resident assessments and support plans was completed 12/25/24 to ensure all assessments and support plans have signatures and dates as required under this regulation 227g.

The Wellness Director or Designee will be responsible for completing an audit and reviewing it in the monthly QI meeting to ensure required signatures and dates for all Initial assessment and support plans and updated support plans have been obtained.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented [redacted]/09/2025)