

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

February 20, 2025

[REDACTED]  
WELL BL OPCO LLC

[REDACTED]  
ATTN BRENDA BACON  
[REDACTED]

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

[REDACTED],  
  
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/19/2024 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,  
[REDACTED]

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

**Legal Entity**

Name: *WELL BL OPCO LLC*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

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

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *81* Waking Staff: *61*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
 Reason: *Complaint* Exit Conference Date: *12/19/2024*

**Inspection Dates and Department Representative**

12/19/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: *92* Residents Served: *54*

**Secured Dementia Care Unit**  
 In Home: *Yes* Area: *Reflections* Capacity: *22* Residents Served: *19*

**Hospice**  
 Current Residents: *4*

**Number of Residents Who:**  
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *54*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *27* Have Physical Disability: *0*

**Inspections / Reviews**

12/19/2024 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/20/2025*

01/28/2025 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: *02/17/2025*  
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *02/07/2025*

Inspections / Reviews *(continued)*

02/20/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/17/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

17 Record Confidentiality

1. Requirements

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

On [REDACTED], at 10:40 AM, the narcotics logbook for the second-floor Secure Dementia Care Unit (SDCU) was unlocked, unattended, and accessible on top of the medication cart in the hallway.

At 10:41 AM assignment sheets for residents in the SDCU were unlocked, unattended, and accessible in an upper cabinet in the memory care kitchen on the second floor.

Plan of Correction

Accept [REDACTED] - 01/28/2025

The Narcotic logbook on top of the medication cart in the hallway of the second floor SDCU was removed and locked in the 2nd floor nursing office at time of survey. Assignment sheets for residents were removed and locked in the 2nd floor nursing office at time of survey.

Nurses and care managers were in-serviced on 12/19/24, 12/23/24 and 1/13/24 as to the requirements under this regulation (see attached training). In-services reviewed plan to keep assignment sheets locked on 1st floor SDCU Program Director's office and 2nd floor SDCU Nursing Office when not in use by care manager staff.

The Wellness Director or Designee will be responsible for audits to ensure resident records are kept confidential and will provide a review at monthly QI beginning January 2025.

Licensee's Proposed Overall Completion Date: 01/15/2025

Implemented [REDACTED] - 02/20/2025

81b Resident Personal Equipment

2. 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

Resident [REDACTED] has a bedside mobility device that is slid under [REDACTED] mattress. The device moves easily when pulled and is not secured to the bed in any way.

Resident [REDACTED] has a bedside mobility device that is slid under [REDACTED] mattress. The device moves easily when pulled and is not secured to the bed in any way.

Resident [REDACTED] has a bedside mobility device that is slid under [REDACTED] mattress. The device is attached to a piece of plywood and moves easily when pulled. The device was not secured to the bed in any way.

Repeat violation: [REDACTED] et al

81b Resident Personal Equipment (continued)

Plan of Correction

Accept [redacted] - 01/28/2025)

Resident [redacted] and [redacted] bed mobility devices have been removed and replaced with a bedside mobility device that meets the requirements under this regulation.

Bedside devices were re audited in all resident rooms to ensure they are securely attached to the structure of the bed. Replacements were made with new bedside mobility devices if the current bedside device did not meet the requirements under this regulation.

Care manager staff was previously in serviced on 11/21/24, 11/26/24 and 12/17/24 as to the requirements under this regulation 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 sheet during the shift in which it is observed. Care Manager Assignment sheets were updated to reflect this requirement and plan (see attached). 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 at monthly staff Town Hall Meetings.

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

Proposed Overall Completion Date: 01/15/2025

Licensee's Proposed Overall Completion Date: 01/15/2025

Implemented [redacted] - 02/20/2025)

82c - Locking Poisonous Materials

3. 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.

Description of Violation

On [redacted] at 10:45 AM, Bath and Beauty nail polish remover, isopropyl alcohol and [redacted], which all had a manufacture's label indicating "Keep out of reach of children and contact poison control if ingested", were unlocked, unattended, and accessible to residents in the second floor memory care kitchen in an unlocked lock box on the bottom shelf of the pantry.

At 10:46 AM, [redacted], which had a manufacture's label indicating "Keep out of reach of children and contact poison control if ingested", was unlocked, unattended, and accessible to residents in the first floor memory care kitchen in a cabinet above the oven.

At 10:59 AM Suave deodorant and sparklefresh toothpaste both which had a manufacture's label indicating "Keep out

**82c - Locking Poisonous Materials (continued)**

of reach of children and contact poison control if ingested", were unlocked, unattended, and accessible to residents in a bin in the bathroom of room [REDACTED].

Not all the residents of the home, including residents in the SDCU, have been assessed as capable of recognizing and using poisons safely.

**Plan of Correction****Accept [REDACTED] - 01/28/2025)**

Nail polish remover and [REDACTED] were removed and locked at the time of survey. The deodorant and toothpaste in room [REDACTED] were removed and locked in a cabinet at time of survey.

Poisonous materials will be locked in a storage locker in the kitchen of the 1st and 2nd floor SDCU and in each resident room and kept inaccessible to residents living in the SDCU.

Care managers were in-serviced on 12/19/24, 12/23/24 and 1/13/25 as to the process above and requirements under this regulation for locking poisonous materials in the SDCU (see attached). Assignments sheets were updated to include an alert to care manager staff regarding this requirement (see attached assignment sheet).

The Wellness Director or Designee will be responsible to complete an audit and provide a review on compliance to this regulation during monthly QI beginning January 2025.

Licensee's Proposed Overall Completion Date: 01/15/2025

**Implemented [REDACTED] - 02/20/2025)****101o - Walls, Floors, Ceilings****4. Requirements**

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

**Description of Violation**

The corner of the ceiling in the back of bedroom [REDACTED], was peeling away exposing dry wall underneath. Resident [REDACTED] indicated that the damage had been there for some time but became worse after a recent heavy rain.

A ceiling tile in memory care bedroom [REDACTED], near the door was stained with a large brown water stain.

**Plan of Correction****Accept [REDACTED] - 01/28/2025)**

The corner of the ceiling in the back of bedroom [REDACTED] that was peeling away and exposing dry wall was repaired and painting completed 1/1/25 (see attached photo). The ceiling tile in memory care bedroom [REDACTED] near the door was stained with a large brown water stain and was replaced with a new ceiling tile on 12/20/24 (see attached photo).

An audit was completed of all resident bedrooms to ensure walls, floors and ceilings are finished, clean and in good repair.

Care Managers and housekeepers will report any walls, floors and ceilings not in good repair to the Concierge, who

101o - Walls, Floors, Ceilings (continued)

will initiate a workorder with our Maintenance department for repair.

Care Managers and housekeepers were in-serviced as to this procedure and the requirements under this regulation on 12/19/24, 12/23/24 and 1/13/25 (see attached training).

The Environmental Services Director will be responsible to complete resident room checks monthly (each room will be audited twice a year) to ensure walls, floors and ceilings are finished, clean and in good repair (see attached audit form). An audit will be presented for review during monthly QI beginning January 2025.

Licensee's Proposed Overall Completion Date: 01/15/2025

Implemented [redacted] - 02/20/2025)

127a - Portable Space Heaters

5. Requirements

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On [redacted] at 10:48 AM, a large plug-in portable space heater that looked like a fireplace was in use in the SDCU second floor activities area. The controls to turn on heat were easily assessable in the front of the unit. When the heat was turned on the temperature read 158.1 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 01/28/2025)

The fireplace with ability to heat was removed at time of survey and is no longer in the community.

All managers were in-serviced on 12/19/24 that no heating devices may be used or placed in the community for decor purposes (see attached training).

The Executive Director (or Designee) will be responsible to provide a review of compliance to the requirements under this regulation at monthly QI beginning January 2025.

Licensee's Proposed Overall Completion Date: 01/15/2025

Implemented [redacted] - 02/20/2025)

141a - Medical Evaluation

6. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The medical evaluation for resident [redacted] who was admitted [redacted], was completed on [redacted] over 60 days prior to admission.

141a - Medical Evaluation (continued)

Plan of Correction

Accept [redacted] - 01/28/2025)

A new Medical Evaluation for resident [redacted] was obtained (see attached).

An audit was completed of all resident Medical Evaluations to ensure compliance to this regulation.

All resident Medical Evaluations will be reviewed by the Executive Director and Wellness Director (or Designee) ongoing to ensure they are completed within 60 days prior to admission or within 30 days after admission.

The Director of Community Relations, Wellness Director and Assistant Wellness Director were in-serviced to this procedure and requirements under this regulation on 12/23/24 (see attached training).

The Executive Director (or Designee) will present a review of compliance to this regulation during monthly QI beginning January 2025.

Licensee's Proposed Overall Completion Date: 01/15/2025

Implemented [redacted] 02/20/2025)

183b - Meds and Syringes Locked

7. Requirements

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

On [redacted] at 10:52 AM, A cellophane roll of [redacted] for resident [redacted] was unlocked, unattended, and accessible in on top of the medication cart in the first-floor SDCU.

Plan of Correction

Accept [redacted] - 01/28/2025)

The cellophane roll of [redacted] for Resident [redacted] was removed from the top of the medication cart and locked inside the cart at time of survey.

All nurses were in-serviced on 12/19/24 that all medication must be kept in an area or container that is locked (see attached).

The Wellness Director or Assistant Wellness Director will be responsible to audit medication carts during daily clinical stand-up meeting to ensure all medication is kept in an area or container that is locked, and that no medication is unlocked, unattended or accessible on top of the medication cart (see attached form).

The Wellness Director or Designee will be responsible to present the audit and review at monthly QI beginning January 2025.

Licensee's Proposed Overall Completion Date: 01/15/2025

183b - Meds and Syringes Locked (*continued*)

*Implemented* [redacted] - 02/20/2025)

233c - Key-Locking Devices

**9. Requirements**

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

**Description of Violation**

*The directions for operating the home's locking mechanism are not conspicuously posted near the first-floor door that exits to the patio in the Secure Dementia Care Unit (SDCU).*

**Plan of Correction**

*Accepted* [redacted] 01/28/2025)

*The picture posted at the 1st floor door by the patio of the SDCU with directions for operating the keypad had fallen from the wall at time of survey. It was immediately reposted at that time.*

*A label identifying the directions for operating the keypad was also placed at the keypad of the 1st floor door by patio of the SDCU (see attached photo).*

*The Environmental Services Director or Maintenance Assistant will be responsible to perform daily audits to ensure directions for operating locking mechanisms are conspicuously posted at exits (see attached form).*

*The Environmental Services Director will be responsible to provide a report on compliance with this regulation at monthly QI beginning January 2025.*

**Licensee's Proposed Overall Completion Date: 01/16/2025**

*Implemented* [redacted] - 02/20/2025)