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

February 20, 2025

[redacted], REGIONAL DIRECTOR OF OPERATIONS
WELL BL OPCO LLC
[redacted]

RE: BRANDYWINE LIVING AT UPPER PROVIDENCE
1133 BLACK ROCK ROAD
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14431

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/07/2025, 01/08/2025 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 UPPER PROVIDENCE* **License #**: *14431* **License Expiration**: *06/13/2025*

Address: *1133 BLACK ROCK ROAD, PHOENIXVILLE, PA 19460*

County: *MONTGOMERY* **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: *I-1* **Date**: *03/31/2015* **Issued By**: *Upper Providence Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *131* **Waking Staff**: *98*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/08/2025*

Inspection Dates and Department Representative

01/07/2025 - On-Site: [redacted]

01/08/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *81*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *26* **Residents Served**: *24*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *81*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *50* **Have Physical Disability**: *1*

Inspections / Reviews

01/07/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/03/2025*

02/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/17/2025*

Inspections / Reviews *(continued)*

02/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

28e - Death of a Resident

1. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on [redacted]. Resident #1's personal belongings were removed from their room on [redacted]; however, resident #1's refund was not issued until [redacted]

For residents under 60 years of age, the home may continue to charge until the room is cleared of the resident's personal property. For residents above 60 years of age, homes must follow the requirements of the Elder Care Payment Restitution Act, enacted on December 9, 2002. Following the death of a resident, the home will pay the personal representative or guardian of the resident the amount of the difference between any payment made and the cost of eldercare actually provided to the resident. This payment shall be made within 30 days from the date that the resident's bedroom is cleared of the resident's personal property. If the resident contract does not distinguish the costs of care from other costs such as room and board, then the Department will cite a violation unless the home refunds the total amount paid for food, shelter, and services for the period following the resident's death. No matter whether the Department cites a regulatory violation, the resident's personal representative or guardian may pursue the remedies available under the Elder Care Payment Restitution Act. See 35 P.S. § 10226.103(b). Personal Care Homes should also be aware that noncompliance with the Elder Care Payment Restitution Act could lead to criminal penalties. See 35 P.S. § 10226.107. Homes are encouraged to develop policies and practices that comply with the Elder Care Payment Restitution Act to address the conditions under which charges may continue to accrue after the death of the resident, as well as the provision of refunds.

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

On 01/13/2025 the Executive Director reviewed regulation 2600.28e and our refund policy with the Business Office Manager (BOM). Upon resident vacating apartment, the BOM or Designee will be responsible for calculating any refunds due and forward information to AP for a check to be issued to the indicated party within 30 days. Every resident discharge will be tracked, reviewed, and audited by ED and BOM for ongoing compliance.
-Please see attached supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

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

44g - Telephone Number

2. Requirements

2600.

44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

44g - Telephone Number *(continued)*

Description of Violation

The telephone numbers of the Department's personal care home regional office, the Disability Rights Network of Pennsylvania (DRP), the Commonwealth Information Center and the personal care home complaint hotline are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 02/07/2025)***

-On 1/7/2025 The telephone numbers of the Department's personal care home regional office, the Disability Rights Network of Pennsylvania (DRP), the Commonwealth Information Center and the personal care home complaint hotline were posted at the front desk, elevator's and near resident mailbox's in large print. ED or designee will be responsible for ensuring compliance of information being posted in conspicuous and public place in our Community, at least monthly.
-Please see attached supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented (- 02/20/2025)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

- Staff person A completed 40th scheduled work hour by However, this staff person did not complete training in the following topics: emergency medical plan, reporting of reportable incidents and conditions.

- Staff person B completed 40th scheduled work hour by However, this staff person did not complete training in the following topics: emergency medical plan, reporting of reportable incidents and conditions.

Plan of Correction ***Accept (- 02/07/2025)***

-On 01/09/2025 Staff Member A and Staff Member B were brought into Brandywine Upper Providence to complete there emergency medical plan training and reporting of reportable incidents and conditions with the ED and HR Director.
-ED and HR Director will be implementing immediately the original Brandywine New Co -Worker Orientation that covers 65(g) Resident rights, Emergency medical plan, Mandatory reporting of Abuse and Neglect under the Older Adult Protective Services Act, and Reporting of reportable incidents and conditions.
-HR Director or designee will audit all new hire charts monthly for the next 180 days to ensure compliance with regulations, ending on 07/07/2025.
-Please see attached supporting documents

65b - Rights/Abuse 40 Hours (continued)

-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

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

65g - Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training in resident rights or falls and accident prevention during training year 2024.

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

-Staff person C will return [redacted] HR Director will complete [redacted] annual training in resident rights and falls and accident prevention on before [redacted] returns to [redacted] department to complete [redacted] shift.
-ED and HR Director updated 2025 Annual Training content to ensure 2600.65g requirements are completed for Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers.
-HR Director will review all employees Monthly Training to stay on track with Brandywine's Annual Training Plan.
-Please see attached supporting documents.
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *02/11/2025*

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

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 01/07/2025 at 10:20 AM, the ice cream freezer next to the kitchen was dirty with spilled ice cream and stained by various substances.

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

-On 01/07/2025 the ice cream freezer next to the kitchen with ice cream was stained with various substances was cleaned immediately.

85a - Sanitary Conditions (continued)

-Dining Service Director or designee will complete a daily audit to ensure that the ice cream freezer is maintained. Audit will be completed by Dining Service Director, Dining Service Manager, or one of the Cook's daily.
-All Dining Staff educated and retrained on the importance of maintaining sanitary conditions at all times on 1/13/2025.
-Please see attached supporting documents.
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

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

85e - Trash Outside Home

6. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 01/08/25 at 11:40 AM, a blue mattress, a set of armchairs and several trash bags containing tablecloths were found on the ground by the designated smoking area.

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

-On 1/08/2025 our Maintenance Director removed the blue mattress, the set of armchairs, and trash bags containing tablecloths immediately.
-On 1/21/25 and 1/22/25 ED and Maintenance Director reviewed with all staff regulation 2600.85.e, Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.
-Executive Director created a daily log to check the perimeter of the community making sure all trash is placed in receptacles. The form will be completed by the Maintenance Director or designee daily.
-Please see attached supporting documents.
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

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

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

- On 01/08/25 at 12:15 PM, the hot water temperature at the kitchen sink in room 221 measured 129.7 degrees Fahrenheit and at 1:44 PM it was 129.9 degrees Fahrenheit.

- On 01/08/25 at 12:25 PM, the hot water temperature at the bathroom sink in room 337 measured 129.9 degrees

89b - Hot Water Temperature (continued)

Fahrenheit and at 1:53 PM it was 130.6 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

*-On 01/08/2025 Brandywine's Regional Director of Plant Operations arrived to Upper Providence at 2:30 PM. The Regional Director of Plant Operations worked with our Environmental Services Director lowering the temperature gauge on the Water Boiler until the water temperature was below 120*F. On 01/08/2025 at 5:30 PM the hot water temperature in room 221 was 118.4*F and at 5:35 PM room 337 was 116.7*F.*
-01/09/2025-01/15/2025 Hot water temperatures were taken daily and logged in real time in various rooms including the rooms of concern by our Environmental Services Director.
-On 01/15/2025 Hot water temperatures were taken weekly and logged in real time in various rooms including the rooms of concern by our Environmental Services Director. This will be ongoing by Environmental Service director or designee.
-Please see supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

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

103g - Storing Food

8. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

A bag of chocolate flavored chips and a bag of dried cranberries were found in the dry food storage area opened and unsealed.

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

-On 01/07/2025 our Dining Service Director disposed of the bag of chocolate flavored chips and the bag of dried cranberries that were found in the dry food storage area opened and unsealed.
-On 01/13/2025 ED and Dining Service Director met with the Dining Service Team to review 2600.103.g. Dining Service Director created and reviewed with the Dining Service Team a Daily Log to make sure all food is stored in closed or sealed containers. See attached Record of Training. See attached Daily Audit Log to be completed by Dining Service Director or designee.
-Please see supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

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

144c1 - Smoking Area Guidelines

9. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c1 - Smoking Area Guidelines *(continued)*

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 01/08/25 at 11:40 AM, several fire hazards were present by the home's designated smoking area including a blue mattress, a set of arm chairs and several trash bags containing tablecloths.

Plan of Correction ***Accept (- 02/07/2025)***

-On 1/08/2025 our Maintenance Director removed the blue mattress, the set of armchairs, and trash bags containing tablecloths immediately that were in close proximity to the designated smoking area.
-Executive Director created a daily log to check the perimeter of the building and smoking area to ensure proper safe guards and prevent any fire hazards . The form will be completed by the Maintenance Director or designee daily.
-On 1/21/25 and 1/22/25 ED and Maintenance Director reviewed regulation 2600.144.c with all staff.
-Please see supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented (- 02/20/2025)

181f - Record of Medication

10. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

Resident #4 had several medications in room on 01/07/24 that are not listed on the resident's Physician's Order Report.

Some of these medications include;

- *Centrum Adults with an expiration date of 05/2024,*
- *Meclizine 12.5 MG Tablets with an expiration date of 12/22/23,*
- *Acetaminophen 500 MG Tablets-the indicated medication is a red tablet; however, several round white tablets were also in this bottle,*
- *Melatonin 5 MG Tablets - with an expiration date that is not legible,*
- *Fluticasone Propionate Nasal Spray 50 MCG - this medication is prescribed to resident #4*

During an interview with resident #4 on 01/08/24, the resident stated staff had come into room on 01/07/24, the first day of the inspection, removed several medications but told the resident the medications would be returned. When licensing representative inquired about this to staff person the Administrator, the medications were brought to the private dining room in a wicker basket containing 13 different medications including those listed above. No medications, including expired or those for the resident , had been disposed of or destroyed.

181f - Record of Medication *(continued)*

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

-On 01/08/2025 Resident #4's medications that were not listed on [redacted] Physician Order Report were clarified with [redacted] physician, orders were obtained, and [redacted] physician order report was updated to reflect all orders.
-On 01/09/2025 ED met with all residents that self medicate and educated them that all new medications including OTC need to be reviewed with their Physician and require an order.
-On 01/09/2025 ED met with Director of Clinical Services and Assistant Director of Clinical Services and reviewed Brandywine Self Medicating Policy and Procedures.
-On 1/21/2025 and 1/22/2025 All Nurse Meeting held by Director of Clinical Services to review 181f, Record of medication requirements.
-Director of Clinical Services or designee will complete a monthly medication audit.
-Please see supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

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

183e - Storing Medications

11. 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 01/08/25 Brimonidine-Timolol 0.2% eye drops for resident #5, was opened and not dated. According to the manufacturer's instructions it is recommended to use the medication within four (4) weeks after opening. Any medicine remaining in the bottle after this period is likely to be contaminated with germs and should no longer be used.

Repeat Violation: 02/12/24.

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

On 01/08/2025 Brimonidine-Timolol 0.2% eye drops for resident #5 was disposed of and reordered. Brimonidine-Timolol 0.2% was delivered in the evening, administered at the next scheduled administration at 9pm, and dated.
-Director of Clinical Services and Assistant Director of Clinical Services conducted an all Nurse and Med Tech training on proper storage of medication and reviewed the Brandywine Medication administration policy.
-Resident's with eye drop's will be audited weekly to ensure proper labeling and storage in accordance to manufacturer's instructions.
-Please see supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

183e - Storing Medications *(continued)*

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

185a - Implement Storage Procedures

12. Requirements

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 01/08/25 at 9:28 AM, resident #6's glucometer read the date and time as 01/08/25 at 10:27 AM.

- While reviewing the January 2025 medication administration record (MAR) for resident #3, several errors were noted in the transcribing of the resident's blood glucose levels. These errors include the following:

- *On 1/3/25 at 1:10 PM, resident #3's glucometer reading was 346; however, it was documented as 364 on the MAR.*
- *On 1/6/25 at 9:18 AM, resident #3's glucometer reading was 73; however, it was documented as 278 on the MAR*
- *On 1/7/25 at 10:42 AM, resident #3's glucometer reading was 78; however, it was documented as "refused" on the MAR.*

Plan of Correction ***Accept ([redacted] - 02/07/2025)***

-On 01/13/2025, Wellness nurses were in-serviced by the Director of Clinical Services in regard to regulation 185a, regarding safe storage, access, security, distribution and use of medications.
-Daily Glucometer audits created, reviewed with all Nurses, and implemented on 01/22/2025 and ongoing.
-In order to prevent transcription errors, Director of Clinical Services or designee to review that glucometer readings match in the EMAR and log book on a weekly basis. Director of Clinical Services to review all glucometer readings beginning on 01/22/2025 and continuing weekly until April 23rd, 2025.
-Please see supporting documents
-Violation will be reviewed at next Quarterly Quality Improvement meeting on 04/09/2025 and ongoing Quality Improvement meeting's throughout 2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented (SW - 02/20/2025)