pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **BRANDYWINE PA HEALTHCARE OPERATIONS LLC**
LEGAL ENTITY

To operate **SILVER SPRINGS AT EAST NORRITON**
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**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

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 **August 14, 2025** until **February 14, 2026**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **151791**

ISSUING OFFICER

Juliet Marsala
ACTING 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.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 14, 2025

[redacted]
CEO
Brandywine PA Healthcare Operations, LLC
2101 New Hope Street
East Norriton, Pennsylvania 19401

RE: Silver Springs at East Norriton
License #: 151791

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 28 and May 8, 2025 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 151790 dated November 6, 2024 to November 6, 2025 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. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 14, 2025 to February 14, 2026.

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.

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.

[redacted]

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:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[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,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SILVER SPRINGS AT EAST NORRITON* **License #:** *15179* **License Expiration:** *11/06/2025*

Address: *2101 NEW HOPE STREET, EAST NORRITON, PA 19401*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *BRANDYWINE PA HEALTHCARE OPERATIONS LLC*

Address: *2101 NEW HOPE STREET, EAST NORRITON, PA, 19401*

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *111* **Waking Staff:** *83*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *05/08/2025*

Inspection Dates and Department Representative

04/28/2025 - On-Site: [redacted]

05/08/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *245* **Residents Served:** *70*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Reflections* **Capacity:** *50* **Residents Served:** *24*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *70*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *41* **Have Physical Disability:** *0*

Inspections / Reviews

04/28/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/01/2025*

Inspections / Reviews *(continued)*

06/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/08/2025*

06/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/01/2025*

08/06/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15b - Supervisor Plan

1. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

Resident # 1 reported two credit cards and $275.00 missing on 4/16/25. The home began an internal investigation, and suspected Staff Member A of this theft on 4/21/25. The home did not suspend this staff member. Additional credit card thefts from Resident # 2 and Resident # 3, occurring between 4/21/25 and 4/25/25, were later reported. Staff Member A was also suspected of those thefts. However, the home did not suspend Staff Member A. The staff member left early on [redacted] then called out sick daily until they were terminated on [redacted]

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Staff Member A was terminated from employment on [redacted] following the internal investigation which confirmed multiple theft allegations.
A written policy and procedure has been developed and implemented on 6/5/2025 requiring the immediate suspension or supervised removal from resident areas of any staff member involved in an allegation of abuse (including theft) pending investigation. Please see attached. All administrative staff, supervisors, and department heads will be trained on the updated abuse allegation response procedures, including the immediate suspension requirement by the Executive Director starting on 6/09/2025 and will be completed by 6/15/2025.
All active or recent allegations will be reviewed to ensure appropriate staff suspension or supervision measures have been applied. This will be completed no later than 6/15/2025.
R/P Executive Director/Designee

Proposed Overall Completion Date: 06/15/2025

Licensee's Proposed Overall Completion Date: *06/15/2025*

Not Implemented ([redacted] - 08/06/2025)

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 2/23/25 at approximately 5:00 P.M. Resident # 4 was observed by staff pushing Resident # 5 in a wheelchair and hitting Resident #5 in the head. Staff Member B separated them and escorted them to dinner. Staff Member B reported the incident to Staff Member C on 2/23/25 and submitted a report on 2/24/25. The home did not report this incident to the department until 2/26/25.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

On 5/30/2025 the Executive Director will start educating the nurses, staff member C and the Director of Wellness

16c - Written Incident Report (continued)

were educated and will be completed no later than 6/15/2025 on the policy of reporting suspected abuse concerns and the importance of the reporting in a timely manner. All suspected abuse must be called in to the Director of Wellness immediately following the incident. The Director of Wellness is to notify the Executive Director immediately after and the Executive Director will do the calling and reporting to DHS and APS within 24 hours of the incident. Executive Director will audit all suspected abuse incidents to assure reporting is completed. Starting on 6/10/2025 the Executive Director will review the home's incident logs weekly for any new entries of suspected abuse to ensure each suspected abuse is documented, communicated, and reported according to protocol ongoing to maintain compliance.
R/P Nurse, Director of Wellness, Executive Director/Designee

Licensee's Proposed Overall Completion Date: *06/15/2025*

Not Implemented ([redacted] - 08/06/2025)

42b - Abuse

3. 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 #4 and #5 [redacted] reside in separate rooms in the home's secured dementia care unit (SDCU). On 2/23/25 at approximately 5:00 P.M., Resident # 4 was pushing Resident #5 in a wheelchair to dinner. Staff Member B observed Resident # 4 hitting Resident # 5 on the top of their head with an open hand. Staff Member B separated the two and took them to dinner at separate tables. Staff Member C evaluated both residents. Resident # 5 had no injuries. Resident # 4 had a small skin tear on the top of their right hand. Resident # 4 reported this was from a bite from Resident #5.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

On 5/30/2025, Staff Member C and the Director of Wellness were educated by the Executive Director on the requirement to report all incidents with injury to DHS.
The Director of Wellness was directed to CC the Executive Director on all reportable incidents submitted to DHS going forward.
R/P: Executive Director
Plan to Come Into Compliance
A written protocol outlining required incident reporting procedures, including reportable injuries, will be distributed to all supervisory staff.
Start Date: 6/6/2025
Completion Date: 6/10/2025
R/P: Executive Director
Targeted training will be provided to all department heads and licensed staff on identifying and reporting incidents with injury.
Start Date: 6/12/2025
Completion Date: 6/14/2025

42b - Abuse (continued)

R/P: Director of Wellness
Effective 5/30/2025, the Director of Wellness is required to CC the Executive Director on every incident report sent to DHS to ensure dual oversight.
Start Date: 5/30/2025
Ongoing
R/P: Director of Wellness
Plan to Maintain and Monitor Compliance
A. 30-Day Audit of Reportable Incidents
The Executive Director will audit 100% of reportable incidents for 30 days to ensure Correct identification of injury-related incidents, timely submission to DHS
Director of Wellness CC'd the Executive Director
Start Date: 5/30/2025
End Date: 6/30/2025
R/P: Executive Director
After the 30-day audit period, the Executive Director or Designee will conduct monthly spot checks of 25% of reportable incidents.
Start Date: 7/1/2025
Frequency: Monthly
Duration: Ongoing
R/P: Executive Director/Designee

Licensee's Proposed Overall Completion Date: *06/15/2025*

Not Implemented ([redacted] - 08/06/2025)

4. 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

On 4/16/25, Resident # 1's Mastercard debit card, and $275.00 were missing from their room. The Mastercard was used three times: On 4/20/25 transactions totaling $180.00 to "CashApp" - a cell phone application used to transfer money - and $53.00 to SAI Gas Station. Resident # 1 canceled this card after reporting fraudulent activity. On 4/25/25 or 4/26/25 that stole debit card was returned and found back on their table in their room, however, the card that replaced this card was then stolen. After this theft, the home conducted an internal investigation and suspected staff member A of the thefts. However, the home did not suspend the staff person or inform other residents of the theft. Staff Member A left the building sick on [redacted] and called out until the home terminated them on [redacted]

On 4/26/25, Resident # 2's Wells Fargo Debit Card and Capital One BJ's Wholesale card were missing from their room. Resident # 2's Power of Attorney (POA) received an alert 4/25/25 that charges were made to the Wells Fargo debit card. 4/25/25 2 charges were made: $20.00 to CashApp and $47.27 to Lyft. The Capital One BJ's Card was not used. The Wells Fargo debit card was canceled and the charges were reversed by the bank.

On 4/25/25, Resident # 3's Union Bank of Switzerland card was missing from their room. Resident # 3's POA received an alert from the bank informing of possible fraudulent charges. Resident # 3's card was used 9 times between 4/25/25 and 4/26/25 at two local shopping malls for a total of $2680.90.

42b - Abuse (continued)

The East Norriton Police investigated this case and issued an arrest warrant for [redacted] for Staff Member A. All direct care workers, nurses, medication technicians, housekeepers, and maintenance have master keys to access all resident bedrooms.

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Staff Member A was terminated from employment on [redacted] following the internal investigation which confirmed multiple theft allegations.
A written policy and procedure has been developed and implemented on 6/5/2025 requiring the immediate suspension or supervised removal from resident areas of any staff member involved in an allegation of abuse (including theft) pending investigation. Please see attached. All administrative staff, supervisors, and department heads will be trained on the updated abuse allegation response procedures, including the immediate suspension requirement by the Executive Director starting on 6/09/2025 and will be completed by 6/15/2025.
All active or recent allegations will be reviewed to ensure appropriate staff suspension or supervision measures have been applied. This will be completed no later than 6/15/2025.
R/P Executive Director/Designee

Proposed Overall Completion Date: 06/15/2025

Directed Plan of Correction (6/10/25 [redacted]

Immediately, the administrator shall inform all residents and resident POAs of the theft incidents and the home's system to safeguard residents' property and possessions.

Within 20 days of the receipt of the acceptable plan of correction, the administrator shall ensure that all staff persons are trained in abuse, abuse prevention, and abuse reporting by a department-approved outside source. Documentation of training shall be kept.

Directed Completion Date: *06/30/2025*

Not Implemented ([redacted] - 08/06/2025)

42x - Safeguard

5. Requirements

2600.
42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

On 5/8/25, 5 residents were interviewed who reported to not have a way to lock their money and/or valuable property. The home does not have a system or a policy in place to safeguard resident possessions. On 4/16/25 and 4/25/25,money and credit cards stolen from three residents' rooms.

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

A new policy regarding the safeguarding of resident money and belongings was developed and implemented on June 5, 2025. As part of this policy, the facility will offer residents the option to utilize a locked box for the secure storage of their personal valuables.
To ensure clear communication and resident choice:

42x - Safeguard (continued)

A notification letter outlining the new policy and offering the option to opt in for a locked box will be distributed to all current residents and their Responsible Parties no later than June 15, 2025.
The Executive Director is responsible for ensuring the timely distribution of this communication.
In addition, the policy has been formally incorporated into the Admission Agreement see section 14.5, 6/5/2025, allowing all new admissions to opt in for a locked box at the time of admission.
This measure is part of the facility's commitment to promoting resident autonomy and safeguarding personal property.

Proposed Overall Completion Date: 06/15/2025

Directed Plan of Correction (6/10/25 [redacted]

In addition to the above, within 15 days of the receipt of the acceptable plan of correction, the administrator shall educate all staff on the newly developed policy/system to safeguard residents' personal property and possessions.

Directed Completion Date: *06/25/2025*

Not Implemented ([redacted] - 08/06/2025)

141a 1-10 Medical Evaluation Information

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. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident # 1's medical evaluation did not include the medication list.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Resident's DME was updated on 5/8/2025 with the signed medication list. Executive Director educated the Director of Wellness on the importance of having the medication listed on the DME or attached to the DME. This education was signed on 3/26/2025. Director of Wellness will audit all charts to verify that all medications are listed or attached to the DME starting on 4/1/2025 and will be completed no later than 5/15/2025. The Director of Wellness will audit all new admissions for the next 3 months starting on 4/1/2025 to ensure we are in compliance.
R/P Director of Wellness/Executive Director/Designee

Licensee's Proposed Overall Completion Date: *06/15/2025*

141a 1-10 Medical Evaluation Information *(continued)*

Not Implemented (- 08/06/2025)

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #4's most recent medical evaluation was completed on

Plan of Correction ***Directed (- 06/10/2025)***

Director of Wellness received new DME on 4/30/2025. Executive Director educated the Director of Wellness on the importance of having the DME completed annually on 5/30/2025. Director of Wellness will audit all charts to verify that all DMEs are completed at least annually. These audits will start on 6/2/2025 and be completed by 6/30/2025. The Director of Wellness will audit all new admissions for the next 30 days starting on 6/2/2025 to ensure we are in compliance.
R/P Director of Wellness/Designee

Proposed Overall Completion Date: 06/15/2025

Directed Plan of Correction (6/10/25

In addition to the above plan, within 15 days of the receipt of the acceptable plan of correction, the administrator or designee shall develop a tracking system to ensure resident annual evaluations are completed timely.

Within 20 days of the acceptable plan of correction, the administrator shall educate all staff responsible for resident medical evaluations on the new tracking system.

Directed Completion Date: *06/30/2025*

Not Implemented (- 08/06/2025)

224a - Preadmission Screen Form

8. 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 #1's preadmission screening form, dated 2/6/24, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept (- 06/10/2025)***

On 5/8/2025 Director of Wellness revised resident's prescreen with that date to reflect that the needs of the resident can be met by the home. Executive Director educated the Director of Wellness on the importance of having the the

224a - Preadmission Screen Form (continued)

preadmission screening completed properly on 5/30/2025. Director of Wellness will audit all charts to verify that all preadmission screenings are completed properly. These audits will start on 6/2/2025 and be completed by 6/30/2025. The Director of Wellness will audit all new admissions for the next 30 days starting on 6/2/2025 to ensure we are in compliance.
R/P Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *06/15/2025*

Not Implemented (- 08/06/2025)

227g -Support Plan Signatures

9. Requirements

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

Description of Violation

Resident # 2 participated in the development of support plan on However, the resident did not sign the support plan.

Plan of Correction ***Accept (- 06/10/2025)***

Director of Wellness had resident #2 sign the support plan on 5/16/2025. Executive Director educated the Director of Wellness on the importance of having all signatures on the care plans on 5/30/2025. Director of Wellness will audit all charts to verify that all care plans are completed with signatures. These audits will start on 6/2/2025 and be completed by 6/30/2025. The Director of Wellness will audit all new admissions for the next 30 days starting on 6/2/2025 to ensure we are in compliance. Resident RASPs (Resident Assessments and Support Plans) are updated annually and as residents' conditions change. The plan has been revised to include ongoing audits of all RASPs to ensure compliance with regulatory requirements. Audits will be conducted quarterly to review a sample of RASPs for timeliness, accuracy, and appropriate updates. These audits will continue on a quarterly basis throughout the year.
R/P Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *06/15/2025*

Not Implemented (- 08/06/2025)

234b - Support Plan Needs Elements

10. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident 4's current assessment, dated does not correctly identify the resident's need of agitation and aggression. The resident progress notes document no problems with agitation and minimal problem with aggression to staff providing care with activities of daily living. On 1/13/25, the resident was reported to have hit resident #4; On 1/16/25, the resident attempted to kick a staff person who was attempting to dress resident #5 On 2/23/25, resident #4 was observed hitting the top of resident #5's head.

Resident # 5's current assessment, dated , does not correctly identify the resident's need of agitation and aggression; both care needs show the resident has no problem. However, Resident #4's progress notes indicate that on 1/16/25, the resident was combative with care. While receiving assistance with care on 2/15/25, the resident

234b - Support Plan Needs Elements (continued)

attempted to bite staff. On 2/23/25, resident #4 stated that a skin tear on the hand was caused by being bitten by resident #5.

Plan of Correction ***Directed (- 06/10/2025)***

Residents 4 and 5 RASPs were updated on 5/6/2025 and 5/14/2025. Executive Director educated the Director of Wellness on the importance of having all the needs of the resident on the care plans and updating the care plans as needed whenever there is a change with the resident's condition including behaviors on 5/30/2025. Director of Wellness will audit all Memory Care charts to verify that they are up to date with the resident's needs . These audits will start on 6/2/2025 and be completed by 6/30/2025. The Director of Wellness will audit all new admissions for the next 30 days starting on 6/2/2025 to ensure we are in compliance.
R/P Director of Wellness/Designee

Proposed Overall Completion Date: 06/15/2025

Directed Plan of Correction (6/10/25

Starting immediately, the administrator or designee shall conduct an audit of resident assessment and support plans of residents of the SDCU monthly for three months to ensure that changes in status are completed and reflected in the support plan.

Directed Completion Date: *06/15/2025*

Not Implemented (- 08/06/2025)

252 - Record Content

11. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident # 2' s record does not include a photograph no more than 2 years old. Resident # 2's most recent photograph is dated

Plan of Correction ***Accept (- 06/10/2025)***

Resident number 2 had a photo in the book at the front desk dated for 9/12/2024. This photo was added to on 5/8/2025. Executive Director educated the Director of Wellness on the importance of keeping the photos of the residents up dated every 2 years on 5/30/2025. Director of Wellness will audit all charts to make sure all photos are within 2 years. Once the audits are completed the Director of Wellness will give the charts to the concierge to update those photos. The audits will start on 6/2/2025 and all photos will be updated by 6/15/2025. The Concierge will maintain a tracking log of resident photograph dates. This log will be reviewed monthly to identify upcoming

252 - Record Content (continued)

photo update deadlines. All resident photographs will be re-taken and updated in their records no later than 2 years from the date of the previous photo. Compliance will be monitored quarterly through internal audits.
R/P Director of Wellness/Concierge/Designee

Licensee's Proposed Overall Completion Date: *06/15/2025*

Not Implemented ([redacted] - 08/06/2025)