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

April 1, 2026

[redacted]
BRANDYWINE PA HEALTHCARE OPERATIONS LLC
[redacted]

RE: SILVER SPRINGS AT EAST NORRITON
2101 NEW HOPE STREET
EAST NORRITON, PA, 19401
LICENSE/COC#: 15179

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/10/2025 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: *SILVER SPRINGS AT EAST NORRITON* **License #**: *15179* **License Expiration**: *02/14/2026*

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: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *114* **Waking Staff**: *86*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *10/10/2025*

Inspection Dates and Department Representative

10/10/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *245* **Residents Served**: *64*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *50* **Residents Served**: *24*

Hospice

Current Residents: *xx*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *64*

Diagnosed with Mental Illness: *20* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *50* **Have Physical Disability**: *4*

Inspections / Reviews

10/10/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/02/2025*

11/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/02/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/08/2025*

Inspections / Reviews *(continued)*

11/17/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/02/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/01/2025*

04/01/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/02/2025*

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] 10:04 AM, the home's 1st floor Wellness office was unlocked and residents' charts were unattended and accessible on the shelves against the wall in one of the two rooms inside the office.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

Immediate Correction Completed

• The Wellness Office door was secured on site immediately upon discovery.

• Staff present on 10/10/2025 were reminded of the requirement to keep the Wellness Office locked at all times when not actively staffed.

• No evidence was found that any resident information was viewed or accessed by residents or unauthorized individuals.

Staff Retraining

Nurses and med techs were retrained on 10/13/2025 by the Wellness Director and will continue with all new hires.:

Protection of resident records

Locking the Wellness Office when not occupied

Maintaining charts out of view and not accessible to residents or visitors

HIPAA and Personal Care Home confidentiality requirements

Training documentation will include:

• Staff sign-in sheet

• HIPPA regulation and education reviewed

Systemic Prevention Measures

To prevent recurrence:

Signage placed reminding staff: "Wellness Office Must Remain Locked When Unattended"

Wellness staff will not leave charts out on desks, counters, when room is open

Daily Wellness Office Security Checks

Start Date: 11/10/2025

Frequency: Daily and each shift

Duration: X 30 days

Responsible parties for documenting: Charge Nurse or Med Tech on Duty

Action Steps: At the beginning and end of each shift, staff will verify that the Wellness Office is locked when not actively staffed.

Confirm charts are secured and not visible or accessible.

Document compliance on the Daily Office Security Log.

Any non-compliance will be reported to the Director of Wellness immediately for corrective action.

Responsible: Executive Director & Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented [redacted] - 04/01/2026)

17 - Record Confidentiality *(continued)*

42c - Treatment of Residents

2. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. On [redacted] around 06:00 PM, while providing incontinence care, staff A and B were audibly complaining about the resident's bed being too low and being pushed against the wall, hurting their backs. Both staff were maneuvering the resident during care in a hasty and rough manner. Resident [redacted] heard staff A say to staff B, "[Resident [redacted]] is giving me a hard road to travel."

Repeat Violation.[redacted]

Plan of Correction ***Accept ([redacted] - 11/17/2025)***

Immediate Corrective Actions Taken on 10/05/2025
Staff A and Staff B were immediately removed from resident care duties pending investigation.
Director of Wellness met with Resident [redacted] that evening to ensure safety, dignity, and emotional wellbeing.
Resident [redacted]'s representative/POA and physician were notified.
Resident [redacted] was assessed and found to have no physical injuries or clinical decline related to the incident.
Incident was reported to DHS and APS within required timeframes.
Investigation
A full internal investigation was conducted, including written statements and interviews with both staff and residents that were on the same care assignments.
Staff A and B were found to have violated resident rights and the home's standards of care.
Based on investigation outcomes, The two agency staff were asked to not return and placed on the DNR list with the agency. Disciplinary action was taken in accordance with company policy, up to and including termination.
Staff Training
All direct care staff, medication technicians, and wellness staff will be retrained on
Resident Rights. Training will be be complete for current staff no later than 11/30/2025
Dignity and respect during care
Mandatory reporting
Training documentation will include:
Sign-in sheet
Pa of aging learning management system was used for the training
To prevent recurrence:
Resident rights refresher training added to orientation and annual training schedule.
Weekly Resident Rights Compliance Checks
Start Date: Week of 11/10/2025
Frequency: Weekly
Duration: x 60 days
Responsible: Director of Wellness/Designee
Action Steps: Verify no complaints or allegations of disrespectful care or rights violations.
Document findings in the Weekly Rights Compliance Audit Form.
If issues identified, initiate corrective action within 48 hours.
Responsible: Director of Wellness/Designee

42c - Treatment of Residents (continued)

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented [redacted] - 04/01/2026)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [redacted], did not receive orientation on the topics listed above.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

Immediate Correction Completed
Staff Person B was removed from direct resident care for allegations of violations of resident rights on 10/05/2025
To prevent recurrence:
A revised orientation checklist was created requiring administrators and HR to verify Fire Safety & Emergency Preparedness training prior to any agency staff being placed on a schedule.
Orientation packet for agency staff now includes:
Fire drill duties
Smoking policy
Fire extinguisher locations
Alarm procedures
Location of designated meeting area
911/emergency call process
Agency has been completely removed from the community. If Agency is ever brought back into the community all agency files will be audited weekly for compliance. Last day an agency team member worked in the community was 10/28/2025.
Responsible: Director of Wellness / HR

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented ([redacted] - 04/01/2026)

81b - Resident Personal Equipment

4. Requirements

2600.

81b - Resident Personal Equipment *(continued)*

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]'s bed is equipped with an uncovered bedside mobility device with openings which exceed the FDA guideline of 4 3/4 inches for both the vertical and horizontal axes with measurements of 7 inches x 7 inches.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

Resident was educated for risk vs benefit for the rail on 10/13/2025. He is alert and oriented x3 and is adamant about having the rail he currently is using. He has agreed to cover the rail with a covering. The recommended Halo was purchased and is not compatible with his bed. The covering for the rail was purchased and the rail will be covered within the next 30 days of today which is 10/31/2025.
Moving forward from 10/31/2025, When a physician gives an order for bedside enablers, it will be conveyed to family and resident that they will need to purchase the state required Halo. This will also be discussed prior to move in with resident and family present. Maintenance Director will be the one to install the enabler to ensure compliance.
Initial Safety Verification of Each Bed Enabler
Start Date: 11/10/2025
Frequency: For each new resident admission or when a device is added
Duration: Ongoing as new residents/equipment are introduced
Responsible: Director of Wellness/Designee
Action Steps:
Document findings on Bed Enabler Initial Safety Checklist.
Place checklist in resident's chart and central safety binder.
Responsible: Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented [redacted] - 04/01/2026)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On [redacted] around 09:40 AM, the home's 1st floor C hallway leading to the Exit at the back of the building had a strong and pungent odor of urine.

Plan of Correction ***Accept [redacted] - 11/03/2025)***

Immediate Corrective Actions Taken on 10/10/2025
The hallway was cleaned, disinfected, and deodorized immediately.
Floor and baseboards were deep-cleaned using enzymatic cleaner to remove odor source.
All trash, linens, and incontinence waste in adjacent areas were removed and disposed of properly.
housekeeping staff will be re-trained on:
Immediate cleanup of incontinence-related spills or leaks
Proper disposal of incontinent products and soiled linens
Use of approved enzymatic cleaners for urine odor control
Reporting and communication procedures to Housekeeping / Supervisor

85a - Sanitary Conditions (continued)

This training will be completed no later than 11/7/2025
Daily hallway sweeps added to housekeeping schedule on all shifts.
Responsible: Director of Maintenance/Designee
Housekeeping Team will use an Odor Control Checklist for all common areas.
Enzymatic cleaner will be stocked on each unit for immediate staff use.
Any spill or odor concerns must be reported to the supervisor immediately.
This checklist will be put in place as soon as the housekeepers are retrained no later than 11/7/2025. Audits will be performed weekly x60 days and then monthly thereafter.
Responsible: Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented ([redacted] - 04/01/2026)

121a - Unobstructed Egress

6. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The Exit door to the back of the building is equipped with a delayed locking device which requires continuous pressure on a "panic bar" for 15 seconds in order to release the lock and exit from the door to the outside. On [redacted] at approximately 09:40 AM, no readily visible, durable signs were present that details the instructions to operate this locking device.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 11/17/2025)***

Immediate Corrective Action Completed on 10/10/2025 By the Maintenance Director
A durable, clearly visible sign with instructions was installed on the back exit door the same day.
Sign was permanently affixed at eye level, with high-contrast letters and durable lamination.
Exit door was tested after installation and functioned correctly.
All delayed egress doors in the community were checked to verify that signage is:
Clearly visible
Durable, weather-resistant if exterior
Contains required operational instructions
Any missing, faded, or damaged signage was replaced.
The location of delayed egress doors
Housekeeping staff will be educated on:
Proper operation in an emergency
Fire drill responsibilities at each exit
How to report missing or damaged signage
This education will be completed no later than 11/7/2025 by the Maintenance Director
Maintenance will conduct weekly audits for 60 days and then monthly there after. These audits will start no later than 11/7/2025
Responsible: Maintenance Director/Designee

121a Unobstructed Egress *(continued)*

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented [redacted] - 04/01/2026)

141a 1-10 Medical Evaluation Information

7. 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 [redacted] initial medical evaluation dated [redacted] did not include weight, height, (5) Advanced Directives, (8) Ability to self administer medications, and (12) Cognitive Functioning.

Repeat Violation: [redacted] et al., [redacted]

Plan of Correction ***Accept ([redacted] - 11/17/2025)***

On 10/13/2025, Director of Wellness contacted Resident [redacted] primary care provider and requested an amended medical evaluation.

The amended evaluation now including weight, height, Advanced Directives, ability to self administer medications, and cognitive functioning was received and filed in the resident's medical chart.

Resident [redacted] s medical record now meets all requirements under 2600.141(a).

Resident Impact Review

All new residents' medical evaluations were reviewed on 10/13/2025 by the Nursing/Wellness Team to verify that all components required by 2600.141(a) are present.

Staff Training / Re education

On 10/13/2025, the Director of Wellness (DOW) retrained wellness department staff responsible for intake and admission paperwork on the regulatory requirements of Initial Medical Evaluations under 2600.141.

The training included:

Required elements of the medical evaluation

Reviewing forms for completeness before acceptance

Training sign in sheet is maintained in the staff training binder.

Monitoring & Audit Plan

To prevent recurrence:

The DOW or designee will audit all new admissions to ensure all required sections of 2600.141(a) are complete prior to admission.

Weekly audits of medical files for new residents will occur for 30 days, then monthly for 3 months.

141a 1 10 Medical Evaluation Information (continued)

Audits will be documented and kept onsite for licensing review.
Responsible: Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented (- 04/01/2026)

141b1 - Annual Medical Evaluation

8. Requirements

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

Description of Violation

Resident 's most recent medical evaluation was completed on

Repeat Violation:

Plan of Correction ***Accept - 11/17/2025)***

Immediate Corrective Action Taken
On 10/13/2025, Director of Wellness contacted Resident attending medical provider and requested an updated annual medical evaluation.
The required medical evaluation was completed and received by the home on 10/13/2025, and is now filed in Resident medical record.
Resident is now in full compliance with the annual evaluation requirement.
Resident Impact Review
On 10/31/2025, the Director of Wellness (DOW) started to review medical evaluation dates from 2025 for all current residents to ensure annual evaluations are completed and within regulatory timelines for 2026. These will be completed no later than 11/30/2025
Any residents found to have expired or soon to expire evaluations will be flagged, and updated evaluations will be requested immediately.
Staff Re Education
On 10/13/2025, the Director of Wellness re educated the Wellness Team on 2600.141(c) requirements:
Annual medical evaluations must be completed within 12 months of the previous evaluation
All evaluation due dates must be tracked in the medical evaluation log
Procedure for requesting updated evaluations 60 days prior to expiration
Staff signed an in service training sheet, kept in the training binder.
Prevention & Monitoring (Addressing Repeat Violation)
To prevent recurrence and correct repeat deficiency:
A Medical Evaluation Tracking Log has been implemented listing due dates for all residents.
The DOW or designee will review the tracking log weekly for 90 days.
A monthly audit of 100% of resident medical evaluations will be conducted and signed by the Director of Wellness to verify continued compliance.
All audits will be kept onsite for licensing review. See attached.
Responsible: Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented (- 04/01/2026)

225a Assessment 15 Days

9. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident[redacted]s assessment and support plan (RASP), dated [redacted] does not include drinking, bladder management, bowel management, ambulation, medication administration, managing and securing healthcare, doing laundry, shopping, securing and using transportation, managing finances, using the telephone, making and keeping appointments, caring for personal possessions, and obtaining clean/seasonal clothing. Additionally, the resident utilizes a bedside mobility device but the resident's need on transferring in/out of bed/chair and turning and positioning in bed/chair is indicated on the RASP as "independent".

Plan of Correction ***Accept ([redacted] - 11/17/2025)***

Immediate Corrective Action Completed
On 10/13/2025, the Director of Wellness reviewed Resident #[redacted] RASP and completed a full update addressing:
Drinking
Bladder management
Bowel management
Ambulation
Medication administration
Managing and securing healthcare
Laundry
Shopping
Transportation
Managing finances
Using the telephone
Making/keeping appointments
Caring for personal possessions
Obtaining clean/seasonal clothing
The support plan was corrected to accurately indicate assistance level required for transferring in/out of bed/chair and turning/positioning in relation to the bedside mobility device.
Updated RASP was reviewed, signed, and placed into Resident [redacted]'s medical record.
Resident Impact Review
Starting on 10/31/2025, the DOW will review all current residents' RASPs to ensure. These audits will be completed by 11/20/2025:
All ADLs and IADLs are addressed
Assistance levels match observed functional ability
All adaptive equipment/mobility devices are accurately documented
Any RASPs found incomplete or inconsistent will be revised and updated.
Staff Re-Education
On 10/31/2025, the Director of Wellness retrained assessment staff on (2):
Required components of the RASP under 2600.227
Ensuring RASP accurately reflects resident's physical abilities and mobility equipment
Training sign-in sheet is maintained in the training binder for DHS review.
Monitoring and Prevention

225a - Assessment 15 Days (continued)

To prevent recurrence:
A RASP Audit Tool has been implemented. The DOW or designee will:
Audit 100% of RASPs for new admissions and readmissions prior to finalization
Care plan meetings will be scheduled to go over RASPs with residents and/or POA via phone or in-person
Any missing components or inconsistencies will be corrected immediately.
Completed audits will be kept onsite for licensing review.
Responsible: Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented (- 04/01/2026)

227g -Support Plan Signatures

10. 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 participated in the development of support plan on . However, the resident did not sign the support plan. The plan is signed by the resident's power of attorney. There is no indication that the resident was unable to sign or refused to sign.

Repeat Violation: et al.

Plan of Correction ***Accept - 11/17/2025)***

Immediate Corrective Action Taken
On 10/13/2025, Director of Wellness obtained a corrected signature for Resident support plan.
The resident was able to sign, and signature was obtained.
The corrected support plan is now on file in Resident 's medical record.
Resident Impact Review
Starting on 10/31/2025, the DOW will review all current residents' RASPs to ensure. These audits will be completed by 12/31/2025:
Any RASPs found incomplete or inconsistent will be revised and updated.
Staff Re-Education
On 10/31/2025, the Director of Wellness retrained assessment staff on (2):
Required components of the RASP under 2600.227
Resident signature is present OR
If resident was unable or refused, documentation with witness signature is documented.
Staff Re-Education
On 10/31/2025, the Director of Wellness retrained assessment staff on (2):
Required components of the RASP under 2600.227
Ensuring RASP accurately reflects resident's physical abilities and mobility equipment and signature requirements.
Training sign-in sheet is maintained in the training binder for DHS review.
Monitoring and Prevention
To prevent recurrence:
A RASP Audit Tool has been implemented. The DOW or designee will:
Audit 100% of RASPs for new admissions and readmissions prior to finalization

227g Support Plan Signatures (continued)

Care plan meetings will be scheduled to go over RASPs with residents and/or POA via phone or in person
Any missing components or inconsistencies will be corrected immediately.
Completed audits will be kept onsite for licensing review.
Responsible: Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *11/07/2025*

Implemented ([redacted] - 04/01/2026)