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

July 16, 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 05/05/2025 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 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**: *83* **Waking Staff**: *62*

Inspection Information

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

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: **Residents Served**: *20*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *55*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *28*

Have Physical Disability: *0*

Inspections / Reviews

05/05/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/31/2025*

06/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/15/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/15/2025*

Inspections / Reviews *(continued)*

07/16/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/15/2025*

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

42c Treatment of Residents

1. Requirements

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

Description of Violation

Resident [redacted] progress note states that on [redacted] resident [redacted] called another resident a bitch during dinner because [redacted] was upset that the resident was sitting at the table where [redacted] was previously seated for meals. Resident [redacted] threaten to remove the resident if [redacted] was not removed.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 06/02/2025)***

Resident [redacted] was seen on 4/29/25 by a certified psychiatric nurse practitioner for increased agitation and behaviors (see notes attached) at which time [redacted] was increased to 20 mg. [redacted] was also seen by [redacted] PCP on 4/15, 4/29, 5/2 and 5/13 prior to being transferred to Chestnut Hill Hospital for an inpatient Behavioral Health stay for medication review and treatment. [redacted] will be re-assessed to determine appropriateness for residency at our community upon completing treatment.

Nursing staff was educated on 5/12 and 5/29 as to the process for internal incident reporting to include both a progress note and notification to the Wellness Director and/or Executive Director (see attached training).

WD, AWD or Designee will be responsible to review progress notes daily for incidents requiring follow up to ensure compliance to this regulation.

The Wellness Director or Designee will be responsible for reviewing the requirements of this regulation at the monthly Nursing Department meeting beginning June 2025 through December 2025.

The Wellness Director or Designee will be responsible for providing a quarterly report on outcomes under this plan of correction during quarterly QI review beginning June 2025 (held in July) through 2025.

Licensee's Proposed Overall Completion Date: *05/28/2025*

Implemented [redacted] - 07/16/2025)

42o Associate/Communicate

2. Requirements

2600.
42.o. A resident has the right to freely associate, organize and communicate with others privately.

Description of Violation

Staff person A stated during an interview with the Department that the family of resident [redacted] and resident [redacted] agreed

42o - Associate/Communicate (continued)

that they could remain friends and socialize in common areas, not in private. Resident [redacted] progress note dated [redacted] states that resident [redacted] was inviting resident [redacted] to [redacted] room to visit overnight; however was told by staff that only family is allowed to visit and stay overnight. Staff person A stated that a door alarm was placed on the resident [redacted] and resident [redacted] bedroom doors following an incident reported to the home on [redacted]. The alarm was installed to prevent the residents from entering each other's bedrooms.

Plan of Correction ***Accept [redacted] - 06/02/2025)***

The door alarm on resident [redacted] and [redacted] doors were removed on 5/5/25. No resident doors have a door alarm.

Staff was in-serviced as to the removal of the door alarms, requirements under this regulation and that all residents have the right to have visitors other than family on 5/7/25 and reviewed again on 5/29/25 (see attached training).

The ED or Designee will be responsible to review the requirements of this regulation at monthly Staff Town Hall beginning May through December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented [redacted] - 07/16/2025)

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Resident [redacted] and resident [redacted] have a door alarm that alerts staff when the bedroom doors opened. Staff person A informed the Department during an interview that a door alarm was placed on the resident's door to prevent them from entering each other's bedroom following the incident reported to the home on [redacted]. Staff person A stated that the door alarm is not audible but sends a notification to staff pagers when the door opens and closes.

Plan of Correction ***Accept [redacted] - 06/02/2025)***

Door alarms on resident [redacted] and [redacted] doors were removed on 5/5/25. No resident doors have a door alarm.

Staff were in-serviced om 5/7/25, 5/12/25 and again reviewed on 5/29/25 as to the requirements under this regulation (see attached trainings).

The Maintenance Director or Designee will be responsible to audit all resident room doors monthly to ensure there are no door alarms present (see attached audit sheet).

The Maintenance Director will be responsible to provide a report on compliance to this regulation at Quarterly QI review for May/June (held July) and quarterly through December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented [redacted] - 07/16/2025)

82c - Locking Poisonous Materials

4. 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

At 9:47 am, Colgate toothpaste was observed in the common bathroom in memory care inside the unlocked vanity, with a manufacturer's label indicating "keep out of reach of children under 6 years of age if more than used for brushing is accidentally swallowed, get medical help or contact poison control center right away ", was unlocked, unattended, and accessible to residents all the home's memory care unit. Not all the residents of the home in the memory care unit have been assessed as capable of recognizing and using poisons safely.

Repeat Violation: [redacted]

Plan of Correction ***Accept*** [redacted] ***- 06/02/2025)***

The tube of Colgate toothpaste was removed from the common area bathroom in the Memory Care Unit at time of survey.

Staff were in-serviced as to the requirements of this regulation on 5/7/25, 5/12/25 and reviewed again on 5/29/25.

The Memory Care Unit is checked by the Wellness Director, Assistant Wellness Director or Designee during daily stand up/stand down meeting for compliance to this regulation (see attached). Additionally, the Manager on Duty will be responsible to check for chemicals and hazardous materials on the Memory Care Unit on weekends (see attached form).

The Memory Care Unit Nurses on each shift will be responsible to ensure chemicals and hazardous materials on the Memory Care Unit are not accessible and are locked (see attached form). Staff was in-serviced to this new procedure on 5/7/25, 5/12/25 and reviewed again on 5/29/25.

The Executive Director will conduct additional weekly audits on the Memory Care Unit to ensure compliance to this regulation.

The Wellness Director and Designee will be responsible to provide a report on compliance to this regulation at Quarterly QI review for May/June (taking place in July) through December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented [redacted] ***- 07/16/2025)***

86b - Bathroom

5. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in resident rooms [redacted] *and* [redacted]*, does not have an operable window or ventilation fan.*

86b - Bathroom (continued)

The common restroom on the 2nd floor near the game room and the common restroom on the 3rd floor near the beauty salon does not have an operable window, or ventilation fan.

Plan of Correction ***Accept [redacted] - 06/02/2025)***

ICS HVAC repair was on site at the community on 5/7/25 and again on 5/16 to assess and attempt to repair the non-operational exhaust fans in resident bathrooms (see attached documentation).

A major component is in need of replacement that communicates with roof top units that provide airflow to exhaust fans (BAS communication system). ICS is preparing a quote for replacement, which is expected to be installed and operational no later than 7/15/25.

Licensee's Proposed Overall Completion Date: *07/15/2025*

Implemented [redacted] - 07/16/2025)

88a - Surfaces

6. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

At 10:05 am, two ceiling tiles near room [redacted] were water stained.

Plan of Correction ***Accept [redacted] - 06/02/2025)***

The two ceiling tiles near room [redacted] with water stains were replaced on 5/5/25 (see attached photo).

The Maintenance Director or Assistant Maintenance Director will be responsible to replace ceiling tiles with water stains after performing their daily walk through in the community. The Maintenance Director and Assistant Maintenance Director were in-serviced to the requirements of this regulation and procedure on 5/5/25 (see attached).

The Maintenance Director or Designee will be responsible to report on compliance to this regulation at quarterly QI review beginning May/June (to take place in July) and quarterly through December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented [redacted] - 07/16/2025)

95 - Furniture and Equipment

7. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At 10:03 am, the exit sign near tower three on the 3rd floor is hanging from the ceiling with the wires exposed.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Accept (- 06/02/2025)***

The exit sign near tower three on the 3rd floor hanging from the ceiling with wires exposed was repaired at time of survey.

The Maintenance Director or Designee will report all repairs needed upon completing a daily walk through at the community and ensure that repairs have been completed timely to remain in compliance with this regulation.

The Maintenance Director and Maintenance Assistant were in-serviced on the requirements of this regulation, and the above process was reviewed on 5/5/25 (see attached training).

The Maintenance Director will be responsible to report on compliance to this regulation at Quarterly QI Review to begin May/June (to take place in July), and quarterly thru December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented - 07/16/2025)

103e - Left Overs

8. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated zip lock bag with fried chicken in the memory care refrigerator.

Plan of Correction ***Accept - 06/02/2025)***

The zip lock bag with fried chicken in the memory care refrigerator was disposed of at time of survey.

The AM and PM cooks or designee will be responsible to check the memory care refrigerators daily to ensure no leftovers are present and will complete a tracker, which will be audited for compliance by the Dining Service Director (see attached form).

Cook staff and Dining Service Director were in-serviced on this procedure and requirements under this regulation on 5/29/25.

The Dining Service Director will be responsible to report on compliance to this regulation at Quarterly QI Review to begin May/June (to take place in July), and quarterly thru December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented - 07/16/2025)

103i - Outdated Food

9. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

There was an unlabeled, undated container of mixed fruit in the memory care refrigerator.

Plan of Correction ***Accept[redacted] - 06/02/2025)***

The mixed fruit in the memory care refrigerator was immediately dated and labeled at time of survey.

The AM and PM cooks or designee will be responsible to check the memory care refrigerators daily to ensure all food is labeled and dated and will complete a tracker, which will be audited for compliance by the Dining Service Director (see attached form).

Cook staff and Dining Service Director were in-serviced on this procedure and requirements under this regulation on 5/29/25.

The Dining Service Director will be responsible to report on compliance to this regulation at Quarterly QI Review to begin May/June (to take place in July), and quarterly thru December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented[redacted] - 07/16/2025)

121a - Unobstructed Egress

10. 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

During the initial physical site at 9:38 am, a recliner chair blocked the exit from the home's memory care dining area.

Plan of Correction ***Accept[redacted] - 06/02/2025)***

The reclining chair was removed from the blocking the exit in the Memory Care Dining Area at time of survey and seating re-arranged to ensure no furniture blocks this exit.

The Maintenance Director, Maintenance Assistant or Designee will be responsible to ensure the egress route to this exit is unblocked during daily walk thru of the community. The Maintenance Director and Maintenance Assistant were in-serviced as to this process and regulation requirements on 5/5/25 (see attached training).

The Maintenance Director will be responsible to report on compliance to this regulation at Quarterly QI Review to begin May/June (to take place in July), and quarterly thru December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented[redacted] - 07/16/2025)

162c - Menus Posted

11. Requirements

2600.

162c - Menus Posted *(continued)*

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of [redacted], to [redacted], was posted in the home's memory care unit. However, the following week was not posted.

Plan of Correction ***Accept [redacted] - 06/02/2025)***

The next week's menu was present on the dining table in the memory care kitchen at time of survey and was posted immediately.

The PM cook will ensure the proper menu is posted in Memory Care each week to remain compliant with this regulation. The Dining Service Director will be responsible to audit and ensure proper menus are posted. The PM cook and Dining Service Director were in-serviced as to this procedure on 5/29/25 (see attached training).

The Dining Service Director will be responsible to report on compliance to this regulation at Quarterly QI Review to begin May/June (to take place in July), and quarterly thru December 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented [redacted] - 07/16/2025)

183d - Prescription Current

12. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], [redacted] prescribed to resident [redacted] was in the home's medication cart; however, the medication was discontinued on [redacted]

Plan of Correction ***Accept [redacted] - 06/02/2025)***

Medication was removed from med cart at time of survey.

On 5/7/25, 5/12/25 and 5/29/25 WD and/or ED in-serviced all medication administrators on regulation 183D, to ensure all discontinued meds are immediately removed from the cart (see attached training). AWD completed med cart audit on 5/6/25. All discontinued and/or expired medications were removed from the Med cart.

Med cart audits will be completed weekly with attached audit sheet for the next 3 months. WD and ED to review at the next QA mtg to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *05/30/2025*

Implemented [redacted] - 07/16/2025)

183e - Storing Medications

13. 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

Resident [redacted] is prescribed [redacted] one tablet by mouth every 8 hours as needed for anxiety. During the medication cart audit, a tear in spot [redacted] and spot [redacted] on the blister pack was covered with tape.

Repeat Violation: [redacted], et al

Plan of Correction ***Accept [redacted] - 06/02/2025)***

[redacted] mg 2 tablets were destroyed at the time of survey.

On 5/7/25, 5/12/25 and 5/29/25 ED and/or ED in-serviced all medication administrators on regulation 183e, to ensure all meds are stored according to manufactures instruction including packages that are damaged (see attached training). WD completed audit of all bingo packs the week of 5/12/25. Any damaged packages were removed from the Med cart. Med cart audits will be completed weekly with attached audit sheet for the next 3 months. WD and ED to review at the next QA mtg to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented ([redacted] - 07/16/2025)

184a - Resident's Meds Labeled

14. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident [redacted] had the incorrect directions listed on the pharmacy label. The resident's current order as of [redacted] is "take one tablet by mouth daily" however the pharmacy label read "take one tablet by mouth daily and the medication label states 30 minutes before breakfast." There was no direction change sticker on the pill bottle.

Resident [redacted] er had the incorrect directions listed on the pharmacy label. The residents' current order as of [redacted] states "take one tablet daily." However, the pharmacy label read "take 1 tablet in the evening." There was no direction change sticker on the pill bottle.

Resident [redacted] had the incorrect directions listed on the pharmacy label. The residents' current order as of [redacted] states "take 2 tablets by mouth as needed." However, the pharmacy label read "take 2

184a Resident's Meds Labeled (continued)

tablets by mouth 3 times daily as needed." There was no direction change sticker on the blister pack.

Repeat Violation: [redacted] et al

Plan of Correction ***Accept [redacted] - 06/02/2025)***

Direction change sticker applied to resident [redacted] medications during survey.

On 5/7/25, 5/12/25 and 5/29/25 ED and/or WD in serviced all medication administrators on regulation 184a. Med cart audits were completed to ensure correct directions on all medications. WD or designee will continue to monitor for ongoing compliance. WD and ED to review at the next QA meeting and quarterly through December 2025 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented[redacted] 07/16/2025)

201 - Positive Interventions

15. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident [redacted] has shown signs of [redacted] and [redacted]. The home has not implemented positive interventions to modify or eliminate the behavior. On [redacted], resident [redacted] progress note states that the resident was aggressive towards staff. On [redacted], resident [redacted] hit a staff member with [redacted] walker, called the staff person a [redacted], pushed the staff and threatened to kill the staff and called the staff a [redacted] and an [redacted]. On [redacted] resident [redacted] called another resident a [redacted] during dinner in the dining room because of seating and threatened to remove the resident if the resident was not removed. Resident [redacted] was redirected to another table. On [redacted], the resident was raising [redacted] voice at the staff.

Plan of Correction ***Accept [redacted] - 06/02/2025)***

Resident [redacted] was seen on 4/29/25 by a certified psychiatric nurse practitioner for increased agitation and behaviors (see notes attached) at which time [redacted] was increased to [redacted]. [redacted] was also seen by [redacted] PCP on 4/29 and 5/13 prior to being transferred to Chestnut Hill Hospital for an inpatient Behavioral Health stay for medication review and treatment. [redacted] will be re assessed to determine appropriateness for residency at our community upon completing treatment.

Resident [redacted] Support Plan was updated to address best approaches and de escalation techniques (see attached RASP). Staff was educated on 5/7/25, 5/12/25 and 5/29/25 as to the Support Plan and best approaches and de escalation techniques to be used in order to reinforce positive outcomes when engaging with Resident [redacted] (see attached training).

If determined that Resident [redacted] is appropriate to continue residency at the community upon completion of

201 - Positive Interventions (continued)

treatment at Chestnut Hill Behavioral Health, Resident [redacted] Support Plan will be reviewed with staff prior to return.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented [redacted] - 07/16/2025)

225c - Additional Assessment

16. Requirements

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

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

Description of Violation

Resident [redacted] most recent assessment was completed on [redacted]. Resident [redacted] has exhibited aggressive behaviors and agitation on the following dates [redacted], and [redacted] the home has not completed a new assessment for resident #[redacted].

Resident [redacted] most recent assessment was completed on [redacted] There was an incident alleging that resident [redacted] was showings of sexual behaviors reported on [redacted], the home did not perform an additional assessment for resident [redacted].

Repeat Violation: [redacted] et al

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

Resident [redacted] and Resident [redacted] have had new RASPS completed on 5/6/25 (see attached).

The Wellness Director or Designee will be responsible for reviewing any new resident behaviors at daily Manager Stand up and a new RASP will be completed. The Wellness Director or Designee will be responsible to review daily stand-up forms monthly to ensure a new RASP has been completed for all new behaviors as a second check. The Wellness Director and Assistant Wellness Director have been in-serviced as to this process (see attached training).

The Wellness Director or Designee will be responsible for providing a quarterly report on outcomes under this plan of correction during quarterly QI review beginning June 2025 (held in July) through 2025.

Licensee's Proposed Overall Completion Date: *05/29/2025*

Implemented [redacted] 07/16/2025)