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

October 1, 2025

[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 07/02/2025 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**: *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: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/27/2003* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *07/02/2025*

Inspection Dates and Department Representative

07/02/2025 - 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**: *27*

Hospice

Current Residents: *4*

Number of Residents Who:

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

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

Have Mobility Need: *40* **Have Physical Disability**: *0*

Inspections / Reviews

07/02/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/25/2025*

08/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/15/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2025*

Inspections / Reviews *(continued)*

08/06/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/15/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/15/2025*

10/01/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/15/2025*

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

16c - Written Incident Report

1. 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 [redacted] resident [redacted] asked staff person A about changes to [redacted] shower schedule. Staff person A spoke to resident 1 in an unprofessional and rude manner saying, "It was changed to Saturday, and [redacted] had to get used to it". Staff person A then entered resident [redacted] room and took down [redacted] shower sign and threw it in the trash. This was witnessed by a third-party physical therapist who then stayed with the resident beyond [redacted] schedule shift to comfort and calm resident [redacted] who had become emotional over the interaction. Resident [redacted] reported then reported this incident to a staff member on site.

On [redacted] that staff member acknowledged the resident had reported having trouble with staff person A , but did not report the incident to management because there were other staff members assigned to the resident's floor that [redacted] should have reported it to.

On [redacted] The third-party physical therapist said [redacted] did not report the incident when it occurred because on [redacted] no management was on-site. Instead, the incident was reported the morning of [redacted].

The home did not report this incident to the department.

Plan of Correction ***Accept ([redacted] - 08/06/2025)***

Mandatory Staff Re-education
By 08/15/2025, all staff will receive refresher training on: Mandatory reporting requirements for incidents/conditions under PA Code §2600.16.
The chain of command and procedures for reporting when management is not on-site. New hires will receive this training during orientation and will sign an acknowledgment form for their personnel file. Posting of Reporting Procedures
Clear written instructions for reporting incidents (including contact numbers for management when off-site) will be posted in staff areas and included in the employee handbook. Leadership Availability A 24/7 on-call administrator/designee will be available for immediate consultation and incident reporting when management is not on-site. Monitoring and Ongoing Compliance
Beginning 08/15/2025 and continuing for 90 days, the Director of Wellness or designee will: Conduct weekly audits of incident reports to ensure all reportable incidents have been submitted to the Department within the required timeframe.
R/P Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *08/05/2025*

Implemented [redacted] - 10/01/2025)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] for resident [redacted] was not signed by the administrator or administrator designee.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 08/04/2025)***

On 7/22/2025, the Executive Director reviewed and signed Resident [redacted] contract to ensure compliance and completion. The signed document was immediately placed in the resident's file and verified for accuracy.
Starting on 7/28/2025 Weekly audits for 60 days by the Executive Director,
all newly signed contracts will be audited to verify both signatures are present and dated.
R/P Executive Director/Designee

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented ([redacted] - 10/01/2025)

42c - Treatment of Residents

3. Requirements

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

Description of Violation

On [redacted], resident [redacted] asked staff person A about changes to [redacted] shower schedule. Staff person A replied: "It was changed to Saturday, and you have to get used to it". Staff person A then entered resident [redacted] room and took down [redacted] shower sign and threw it in the trash. This was witnessed by a third-party physical therapist who then stayed with the resident beyond [redacted] schedule shift to comfort and calm resident [redacted] who had become emotional over the interaction. Resident [redacted] then reported this incident to a staff member on site who failed to report it to the home because the resident was not residing on [redacted] assigned floor.

Plan of Correction ***Accept [redacted] 08/04/2025)***

Staff Person A was re-educated on 7/3/2025 by the Director of Wellness regarding appropriate, respectful communication, resident rights under PA Code §2600.18 (Dignity and Respect), and professional conduct expectations.
A written warning was issued to Staff Person A, and the incident was documented in the employee's personnel file.
Resident 1 was immediately assessed by the Director of Wellness on 7/2/2025 to address emotional distress and to reinstate their preferred shower schedule.
Starting 7/28/2025 Director of Wellness will conduct random resident interviews and observations weekly to ensure respectful communication and resident comfort with their care routines. These interviews will be done until August 31, 2025
R/P Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *07/28/2025*

42c - Treatment of Residents *(continued)*

Implemented [redacted] - 10/01/2025)

62 - Contact List

5. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person B, the administrator, maintains a list of staff persons that does not include staff persons that are in training. Staff person B stated that these staff persons are not added until they receive their first paycheck.

Plan of Correction ***Accept [redacted] - 08/06/2025)***

On 7/3/2025, the Business office Director immediately updated the staff list to include all active trainees, including those who have not yet received a paycheck. A review of personnel records was conducted to ensure all current staff and trainees are reflected on the roster, by the Business Office Manager.
Executive Director Educated the Business Office Manager on Compliance with § 2600.65(c) – Staff Listing Requirements on 7/25/2025
Details: Training will cover:
Maintaining a real-time, accurate staff list which includes all trainees, part-time, PRN, and newly onboarded staff.
Monitoring for Ongoing Compliance: Beginning 08/15/2025, the Business Office Manager or designee will: Review and Update Staff List Weekly
Confirm that the staff roster includes all active employees and trainees (including those who have not yet received a paycheck, PRN, and part-time staff). Compare roster against timekeeping and onboarding records to identify any missing individuals.
Monthly Audit by Executive Director will start no later than 08/27/2025. The Executive Director will review the roster monthly for accuracy. Any discrepancies will be corrected immediately, and retraining provided if necessary.
Maintain a log of all weekly roster reviews and monthly audits for a period of 12 months for review by the Department during inspections.
R/P Executive Director/Business Office Manager/Designee

Licensee's Proposed Overall Completion Date: *08/05/2025*

Implemented [redacted] - 10/01/2025)

65i - Training Record

6. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

65i - Training Record *(continued)*

Description of Violation

The home's record of direct care staff training titled "POC Education for Director of Wellness and Nurse" does not include the length of training.

Plan of Correction ***Accept [redacted] - 08/04/2025)***

On 7/3/2025, Executive Director updated the training record titled "POC Education for Director of Wellness and Nurse" was immediately updated to include the missing duration of training.
The corrected document now reflects that the training occurred on 5/30/2025 and 6/3/2025 and lasted 45 minutes.
Effective immediately 7/24/2025, all future staff training documentation will be completed on the DHS record of training form to include the following standardized fields:
Date of training
Name and title of trainer(s)
Names and titles of attendees
Topic(s) covered
Training method (e.g., in-person, online)
Duration of training (start and end time or total hours)
Business Office Manager will audit all future record of training forms monthly for the next 3 months to ensure all information is complete stating 7/24/2025.
R/P Business office manager/Designee

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented [redacted] 10/01/2025)

82c - Locking Poisonous Materials

7. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted] at 2:19 PM a tube of Crest pro-health toothpaste and Crest whitening toothpaste, with a manufacture's label indicating "if more then used for brushing is accidentally swallowed get help or call poison control right way", was unlocked, unattended, and accessible to residents in the bathroom of Secure Dementia Care Unit (SDCU) room [redacted]
The doors to room [redacted] and its bathroom were wide open. Not all the residents of the home, including resident [redacted], have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 08/04/2025)***

On 7/2/2025, upon discovery of the unsecured toothpaste, the items were immediately removed from the bathroom by the care manager and placed in a locked closet inaccessible to residents. All memory care staff will be reeducated on the poisonous material requirements for the SDCU unit. This education will be completed by 7/31/2025 by the Director of Wellness. Daily audits will be completed by the Director of Wellness for the next 30 days starting on 8/1/2025 to ensure no poisonous materials are left out in the residents rooms on the SDCU unit.
R/P Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *07/31/2025*

82c - Locking Poisonous Materials *(continued)*

Implemented [redacted] 10/01/2025)

85a - Sanitary Conditions

8. Requirements

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

Description of Violation

On [redacted] at 2:13 PM, there was a soiled incontinence brief on the floor of the shower of room [redacted].

Plan of Correction ***Accept ([redacted] 08/04/2025)***

On 7/2/2025, the soiled brief was immediately removed by the care manager and the shower thoroughly sanitized by housekeeping staff. The resident's bathroom was inspected by the Director of Wellness for any other hazards, and no additional concerns were noted at the time.
On 7/31/2025, all direct care staff and housekeeping staff were re-educated on:
Proper disposal of soiled incontinence products immediately after use.
The importance of maintaining sanitary conditions in all resident bathrooms and showers.
Procedures for documenting and reporting unsanitary conditions observed during care or cleaning. Staff were reminded to ensure all used incontinence products are properly disposed of in designated receptacles during and after personal care routines. Daily Room Checks: The Director of Wellness will conduct daily visual inspections of all resident bathrooms for 30 days starting on 8/1/2025 confirming that all personal care waste has been removed.
R/P Director of Wellness/Designee

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 10/01/2025)

85e - Trash Outside Home

9. 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 [redacted] at 9:38 AM there was a 30-foot green uncovered dumpster outside the home that staff described as permanent. Present next to the dumpster, on the ground, was a leather recliner.

Plan of Correction ***Accept [redacted] - 08/04/2025)***

On 7/2/2025, the Director of Maintenance discarded the leather recliner. The area around the dumpster was cleaned and inspected to ensure no other debris or hazards were present. Dumpster Covering: On 7/21/2025, a secure cover was installed on the dumpster to ensure waste is contained and not exposed to the environment, residents, or wildlife. On 7/31/2025, all maintenance, housekeeping, and relevant direct care staff will be trained on:
Proper disposal of trash and large items
Reporting procedures for any bulk items requiring removal
Maintaining the dumpster area in a clean and sanitary condition
Starting on 8/1/2025 for the next 30 days The Maintenance Director or designee will perform daily checks of the dumpster area to ensure:
The cover is attached and secure

85e Trash Outside Home (continued)

No items are left on the ground
The area is clean and secure
R/P Director of Maintenance/Designee

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] 10/01/2025)

101j7 - Lighting/Operable Lamp

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 08/04/2025)***

On 7/2/2025, the Maintenance Director placed a bedside lamp with an accessible on/off switch was installed in Resident [redacted] bedroom. The lamp was tested to ensure safe operation and proper brightness, and the resident was shown how to operate it independently. Between 8/1/2025 and 8/10/2025, the Maintenance Director will complete a full inventory of all resident rooms on the SDCU to ensure that each room has a bedside light that is:
Within reach of the resident when in bed
Functioning properly
Equipped with a switch or mechanism the resident can operate
R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented ([redacted] - 10/01/2025)

121a - Unobstructed Egress

11. 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

On [redacted] at 2:49 PM, a paper with a picture of a red stop with the words "Stop" was adhered to the emergency exit door on the first floor in stairwell B.

Plan of Correction ***Accept [redacted] 08/04/2025)***

On 7/2/2025, the "Stop" sign was immediately removed by the Maintenance Director from the emergency exit door in Stairwell B. The door was inspected to ensure it was functioning properly and that no barriers, delays, or deterrents remained. On 7/31/2025, all staff will be re trained on:
Proper identification and use of emergency exits

121a Unobstructed Egress (continued)

Restrictions on signage placement near emergency exits
The importance of maintaining compliance with fire and life safety codes
Beginning 8/1/2025, the Maintenance Director or designee will conduct monthly for 3 months fire safety audits to ensure all emergency exits are:
Clear of obstructions
Free of inappropriate signage or visual deterrents
Fully functional and compliant with all safety regulations
R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented ([redacted] - 10/01/2025)

252 - Record Content

12. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.

252 Record Content *(continued)*

24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident [redacted] record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept [redacted] 08/04/2025)***

On 7/10/2025, a current photograph of Resident [redacted] was taken with consent and immediately uploaded into the resident's record by the front desk concierge. The outdated photograph was removed to ensure compliance. Photo Compliance Audit: From 7/10/2025 to 7/31/2025, the Front Desk Concierge or designee will complete an audit of all resident records to ensure that each contains a photograph that is less than 2 years old. All staff responsible for assessments and documentation will be re educated on 7/31/2025 about the importance of maintaining updated resident photos and the steps to follow if a photo needs to be retaken.
R/P Front Desk Concierge/Designee

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 10/01/2025)