Pennsylvania Department of Health
Inspection Results

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BGI OF BRANDYWINE, INC
1375 NEWARK ROAD
KENNETT SQUARE, PA 19348

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 06/11/2015

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection, and inspection conducted for the approval to use a narcotic agent, specifically methadone and buprenorphine in the treatment of narcotic addition. This inspection was conducted on June 10 - 11, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, BGI of Brandywine, Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection.

Plan of Correction

704.11(a) LICENSURE Staff Development Procedure
704.11. Staff development program. (a) Components. The project director shall develop a comprehensive staff development program for agency personnel including policies and procedures for the program indicating who is responsible and the time frames for completion of the following components:

Observations
Based on a review of administrative documentation, the facility failed to provide a comprehensive staff development program.

The findings include:

On June 10 - 11, 2015, the facility's comprehensive staff development program was requested. The facility failed to provide a comprehensive staff development program which included an assessment of staff training needs, an overall plan for addressing these needs, and an annual evaluation of the overall training plan.

The findings were reviewed with facility staff during the licensing process.

Plan of Correction
The facility does have a Comprehensive Staff Develop Plan in accordance with DDAP licensing requirements. Unfortunately, we overlooked submitting it during the licensing visit and can provide to you upon request. It includes an assessment of staff training needs, an overall plan for addressing these needs and an annual evaluation of the overall training plan. We are revising our system for tracking and making this Staff Development Plan a part of QM. QM will begin to track hire dates and training dates. The spreadsheet will be updated and distributed to all managers quarterly so all staff are aware of training needs, requirements, onsite training schedules. The spreadsheet and calendar will be available by 8/15/15.

704.11(b)(1) LICENSURE Individual training plan.
704.11. Staff development program. (b) Individual training plan. (1) A written individual training plan for each employee, appropriate to that employee's skill level, shall be developed annually with input from both the employee and the supervisor.

Observations

Plan of Correction

Based on a review of personnel records and a review of the Staffing Requirements Facility Summary Report form (SRFSR), the facility failed to document an annual written individual training plan for employees.

The findings include:

Six personnel records were reviewed for documentation of an individual training plan on June 10, 2015. The facility failed to document an individual training plans in six of six counselor records reviewed; specifically personnel records, # 1, 2, 3, 4, 5 and 6.

In addition, based on an interview with facility staff and documentation on the SRFSR form, at least 20 support staff failed to receive an annual written individual training plan.

The facility's training year was January 1, 2015 to December 31, 2015. All 20 of the support staff were hired prior to the 2014 training year.

The findings were reviewed with facility staff during the licensing process.

1. According to an individual?s needs, each staff member will be expected to develop an Individual Training Plan in coordination with, and approval of, their direct Supervisor.

2. Staff members will submit their Individual Training Plan annually.

3. Records of the annual Individual Training Plans will be tracked by the Quality Improvement Department. Records of staff who have yet to complete an Individualized Training Plan will be disseminated to both the employee and their immediate Supervisor.

4. The immediate Supervisor will hold their staff accountable for completing their annual Individual Training Plan

Responsible Person: Director of Quality Improvement, Education and Utilization Review

704.11(c)(1) LICENSURE Mandatory Communicable Disease Training

704.11. Staff development program. (c) General training requirements. (1) Staff persons and volunteers shall receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

Observations

Based on a review of the Staffing Requirements Facility Summary Report form (SRFSR), the facility failed to ensure staff persons and volunteers received a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

The findings include:

The SRFSR form was completed by the facility on June 11, 2015. The facility failed to ensure staff persons and volunteers received a minimum of 6 hours of HIV/AIDS and at least 4 hours TB/STD training.

Plan of Correction

The following staff have been scheduled for training:

Employee #7 is registered to take HIV/AIDS on 9/9/15 and TB/STD on 9/11/15.

Employee #8 resigned effective 7/31/15.

Employee#9 is registered to take HIV/AIDS on 9/9/15 and TB/STD on 9/11/15.

Employee #10 resigned effective 7/10/15.

The Administrative Assistant is registered to take HIV/AIDS on 9/25/15 and TB/STD on 10/2/15.

Employee#11 is registered to take HIV/AIDS on 9/9/15 and TB/STD on 8/5/15.

Employee#12 is registered to take HIV/AIDS on 9/25/15 and TB/STD on 10/2/15.

Employee#13 is registered to take HIV/AIDS on 9/25/15 and TB/STD on 10/2/15.

Employee # 7, a counselor was hired March 11, 2013. The facility failed to ensure employee # 7 completed HIV/AIDS & TB/STD training by March 11, 2014 or by the time of inspection.

Employee # 8, a counselor was hired January 3, 2013. The facility failed to ensure employee # 8 completed HIV/AIDS & TB/STD training by January 3, 2014 or by the time of inspection.

Employee # 9, a counselor was hired June 3, 2013. The facility failed to ensure employee # 9 completed HIV/AIDS & TB/STD training by June 3, 2014 or by the time of inspection.

Employee # 10, a counselor was hired September 18, 2013. The facility failed to ensure employee # 10 completed HIV/AIDS & TB/STD training by September 18, 2014 or by the time of inspection.

In addition, numerous support staff had not received HIV/AIDS & TB/STD training within the first 2 years of employment, or by the time of inspection.

The administrative assistant was hired June 3, 2013. The facility failed to ensure that the administrative assistant completed HIV/AIDS & TB/STD training by June 3, 2015.

Employee # 11, a receptionist was hired November 27, 2012. The facility failed to ensure that employee # 11 completed HIV/AIDS & TB/STD training by November 27, 2014.

Employee # 12, a receptionist was hired April 17, 2013. The facility failed to ensure that employee # 12 completed HIV/AIDS & TB/STD training by April 17, 2015.

Employee # 13, a maintenance assistant was hired July 7, 2011. The facility failed to ensure that employee # 13 completed HIV/AIDS & TB/STD training by July 7, 2013.

Employee # 14, a maintenance assistant was hired June 23, 2004. The facility failed to ensure that employee # 14 completed HIV/AIDS & TB/STD training by June 23, 2006.

Employee # 15, a patient account rep was hired October 22, 2012. The facility failed to ensure employee # 15 completed

Employee#14 is registered to take HIV/AIDS on 9/25/15 and TB/STD on 10/2/15.

Employee#15 is registered to take HIV/AIDS on 9/25/15 and TB/STD on 10/2/15.

Employee#16 has been taken off the schedule until she can register for the required trainings.

Furthermore, QM will begin to track hire dates and training dates. The spreadsheet will be updated and distributed to all managers quarterly so staff are aware of the timelines for required trainings.

HIV/AIDS & TB/STD training by October 22, 2014.

Employee # 16, a nurse assistant was hired November 7, 2012. The facility failed to ensure that the employee # 16 completed HIV/AIDS & TB/STD training by November 7, 2014.

The findings were reviewed with facility staff during the licensing inspection.

704.12(a)(3)(i) LICENSURE NonHosp Rehab

704.12. Full-time equivalent (FTE) maximum client/staff and client/counselor ratios. (a) General requirements. Projects shall be required to comply with the client/staff and client/counselor ratios in paragraphs (1)-(6) during primary care hours. These ratios refer to the total number of clients being treated including clients with diagnoses other than drug and alcohol addiction served in other facets of the project. Family units may be counted as one client. (3) Inpatient nonhospital treatment and rehabilitation (residential treatment and rehabilitation). (i) Projects serving adult clients shall have one FTE counselor for every eight clients.

Observations

Based on a review of the Staffing Requirements Facility Summary Report form (SRFSR), the facility failed to ensure the residential treatment program maintained one FTE counselor for every eight clients.

The findings include:

The SRFSR form was reviewed on June 10, 2015. The facility provides 460 hours per week for the residential treatment program, and has a total of 110 active clients.

The residential treatment program computation is as follows:

460 hours per week divided by a 35 hour work week = 13.142 full-time equivalent for determining the ratio

110 active clients divided by 13.142 = 8.370 FTE

Their ratio comes out to 9:1

The findings were reviewed with facility staff during the licensing inspection.

Plan of Correction

1. A second Clinical Supervisor was hired on July 13, 2015.

2. When a Counselor vacancy occurs, an immediate response will be made to refill the position, including, but limited by, immediately advertising the vacant position.

3. Clinical Supervisors have set aside adequate blocks of time each week to interview potential candidates.

4. Both clinical supervisors are aggressively reviewing resumes, scheduling and conducting interviews to hire for the vacant counselor positions to bring our client/counselor ratios back into compliance. Offers are being made on a timely basis to qualified candidates.

5. As of July 31, we have three pending applicants for vacant positions. Assuming all applicants pass background checks and other preliminaries, Bowling will be in compliance with staffing ratios.

Responsible person: Clinical Supervisors

705.10 (d) (1) LICENSURE Fire safety.

705.10. Fire safety. (d) Fire drills. The residential facility shall: (1) Conduct unannounced fire drills at least once a month.

Observations

Based on a review of the fire drill log, the facility failed to conduct a fire drill during sleeping hours at least every 6

Plan of Correction

1. Bowling Green maintains a yearly schedule of fire drills

months.

The findings include:

On June 10, 2015, the fire drill logs were reviewed covering the period of May 30, 2014 through May 3, 2015.

The facility failed to conduct a fire drill during sleeping hours at least every 6 months.

The facility documented fire drills during sleeping hours on July 9, 2014 and April 24, 2015.

The findings were reviewed with facility staff during the licensing inspection.

2. Fire drills will be unannounced. The fire drill schedule will be kept confidential, will occur monthly, and consists of quarterly fire drills per shift each year.

a. The knowledge of the fire drill schedule will be disseminated to two maintenance personnel only.

b. Fire drills will be conducted on different days of the week

3. Fire drill procedures will be followed:

a. Notify the fire department that a drill is being conducted

b. Pull the alarm.

c. All personnel and staff will evacuate the premises according to established exit routes and congregate in the pre-established location. Elevators will not be used.

d. Attendance will be taken of all staff and Residents

4. Written fire drill records with date, time, problems encountered, etc. will be maintained.

5. Compliance with the fire drill plan will be tracked by the Maintenance Department and Bowling Green?s Quality Improvement Director.

Responsible persons: Director of Maintenance and Construction Management

Director of Quality Improvement, Education, and Utilization Review

715.17(c)(2) LICENSURE Medication control

(c) A narcotic treatment program shall develop and implement written policies and procedures regarding the medications used by patients which shall include, at a minimum: (2) Drug storage areas. A narcotic treatment program shall develop and implement written policies and procedures regarding storage of medications and access to the medication storage area. Agents shall be stored in a locked safe that has been approved by the DEA under 21 CFR 1301.72 and 1301.74 (relating to physical security controls; and other security controls).

Observations

Based on a physical plant inspection, the facility failed to store narcotic treatment agents in a locked safe that has been approved by the DEA under 21 CFR 1301.72 and 1301.74 (relating to physical security controls; and other security controls).

The findings include:

A physical plant inspection was conducted on June 11, 2015. The facility failed to maintain narcotics in a separate double-lock box.

Buprenorphine, specifically Subutex was observed in a drawer on the medication cart. The Subutex was not secured in a locked safe as approved by the DEA; in addition, this narcotic was in a drawer with other medication.

Plan of Correction

The identified medication cart that was located in the Detox medication room that has the Buprenorphine specifically Subutex was replaced on 6/12/15 with one that has a separate double locked box as required and approved by DEA standards under 21 CFR 1301.72 and 1301.74.(relating to physical security controls; and other security controls.) All Nursing staff was educated on the importance of keeping this medication drawer locked at all times with only Buprenorphine tablets in it on 6/12+15/15. Random checks to ensure the Buprenorphine is in a separate double lock drawer will be completed during our monthly DEA standards audit.

Responsible person: Director of Nursing

"(1) Where small quantities permit, a safe or steel cabinet;"

The findings were reviewed with facility staff during the monitoring inspection.

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BGI OF BRANDYWINE, INC
1375 NEWARK ROAD
KENNETT SQUARE, PA 19348

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Survey conducted on 11/25/2015

INITIAL COMMENTS

This report is a result of a complaint investigation conducted on November 9, 2015 and a follow-up investigation conducted on November 25, 2015 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the complaint investigation, the allegations against BGI of Brandywine, Inc. were partially substantiated. No areas of noncompliance with the applicable chapters of 28 PA Code which pertain to the facility were identified during this investigation; therefore, no plan of correction is required.

Plan of Correction

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BGI OF BRANDYWINE, INC
1375 NEWARK ROAD
KENNETT SQUARE, PA 19348

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Survey conducted on 06/22/2016

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection, and inspection conducted for the approval to use a narcotic agent, specifically methadone and buprenorphine in the treatment of narcotic addiction. This inspection was conducted on June 20-22, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection, BGI of Brandywine, Inc., was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

704.11(c)(1) LICENSURE Mandatory Communicable Disease Training

704.11. Staff development program. (c) General training requirements. (1) Staff persons and volunteers shall receive a minimum of 6 hours of HIV/AIDS and at least 4 hours of tuberculosis, sexually transmitted diseases and other health related topics training using a Department approved curriculum. Counselors and counselor assistants shall complete the training within the first year of employment. All other staff shall complete the training within the first 2 years of employment.

Observations

Twenty-four personnel records were reviewed on June 20-22, 2016. The facility did not provide documentation of the required 6 hours HIV/AIDS and 4 hours TB/STD training in eight of twenty-four personnel records reviewed.

Employee # 17, an admissions coordinator, was hired November 21, 2013. The facility failed to ensure employee # 17 completed HIV/AIDS training by November 21, 2015.

Employee #18, a clinical technician, was hired September 4, 2013. The facility failed to ensure employee #18 completed HIV/AIDS and TB/STD training by September 4, 2015.

Employee #19, a clinical technician, was hired July 13, 2013. The facility failed to ensure employee #19 completed HIV/AIDS and TB/STD training by July 13, 2015.

Employee #20, a patient accounts rep, was hired July 30, 2013. The facility failed to ensure employee #20 completed HIV/AIDS training by July 30, 2015.

Plan of Correction

As of June 17 all but one of the eight identified employees have taken both HIV/AIDS and TB/STD trainings.

Employee #19 will be scheduled to take HIV on 9/7/16 and TB/STD on 9/9/16.

Furthermore, three nursing staff have been trained to present these trainings on-site. Both HIV/AIDS and TB/STD will be held on-site at Bowling Green every six months.

QM will track hire dates and schedule employees for these trainings within the required time frames.

Employee #21, an admissions coordinator, was hired March 1, 2013. The facility failed to ensure employee #21 completed HIV/AIDS and TB/STD training by March 1, 2015.

Employee #22, a receptionist, was hired April 17, 2013. The facility failed to ensure that employee #22 completed HIV/AIDS and TB/STD training by April 17, 2015.

Employee #23, office manager, was hired November 4, 2013. The facility failed to ensure that employee #23 completed HIV/AIDS and TB/STD training by November 4, 2015.

Employee #24, a counselor, was hired January 28, 2015. The facility failed to ensure that employee #24 completed HIV/AIDS and TB/STD training by January 28, 2016.

These findings were reviewed with facility staff during the licensing process.

This is a repeat citation.

The facility was previously cited for noncompliance of this standard during the June 11, 2015 Licensing inspection.

709.28 (c) (1) LICENSURE Confidentiality

§ 709.28. Confidentiality. (c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to: (1) Name of the person, agency or organization to whom disclosure is made.

Observations

Based on a review of client records on June 20-21, 2016, the facility failed to obtain an informed and voluntary consent in ten of twenty-three client records. The "Authorization for Release of Information" form did not contain documentation of the client's right to verbally revoke a signed consent for the release of information. The facility's "Authorization for Release of Information" form documented, "I may revoke this authorization at any time. Revocations to this authorization must be presented in writing."

Plan of Correction

Our Release of Information forms were revised and put in to use on May 16, 2016 and now state "I may revoke this authorization at any time. Revocations to this authorization may be requested verbally or in writing."

The Admissions Director will review 20 charts per month to ensure we are using the correct Release forms to meet this regulation.

Client #4 was admitted on January 4, 2016 and was discharged on January 9, 2016. An undated consent to the funding source failed to comply with 42 CFR as the consent only allowed the client to revoke their consent form in writing.

Client #6 was admitted on April 30, 2016 and was discharged on May 5, 2016. A consent dated 4/30/2016 to the funding source failed to comply with 42 CFR as the

consent only allowed the client to revoke their consent form in writing.

Client #7 was admitted on May 9, 2016 and was discharged May 22, 2016. A consent dated 5/9/2016 to the funding source failed to comply with 42 CFR as the consent only allowed the client to revoke their consent form in writing.

Client #11 was admitted on April 5, 2016 and was discharged April 10, 2016. Consents dated 4/5/2016 to the funding source and a pharmacy failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #12 was admitted on April 8, 2016 and was discharged April 19, 2016. Consents dated 4/8/2016 to the funding source, referral source, employer and pharmacy failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #13 was admitted February 9, 2016 and was discharged March 10, 2016. Consents dated 2/9/2016 to the funding source, pharmacy and primary care physician failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #14 was admitted January 18, 2016 and was discharged February 13, 2016. Consents dated 1/18/2016 to the funding source and primary care physician failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #15 was admitted December 4, 2015 and was discharged January 1, 2016. Consents dated 12/4/2015 to the funding source, employer, and primary care physician failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #22 was admitted April 7, 2016 and was discharged April 12, 2016. Consents dated 4/7/2016 to the funding source and a government agency failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

Client #23 was admitted February 10, 2016 and was discharged March 7, 2016. Consents dated to the funding source, pharmacy, government agency failed to comply with 42 CFR as the consent only allowed the client to revoke their consent forms in writing.

These findings were reviewed with facility staff during the licensing process.

709.28 (d) LICENSURE Confidentiality

§ 709.28. Confidentiality. (d) A copy of a client consent shall be offered to the client and a copy maintained in the client record.

Observations

Based on a review of twenty-three client records on June 20-22, 2016, the facility failed to offer a copy of a consent to release information to the client in three of twenty-three client records reviewed.

Plan of Correction

As of August 1, 2016 all staff will be re-trained to document that a copy of the consent was offered to the client. The Admissions Director will review 20 charts per month to ensure this regulation is met.

Client #4 was admitted on January 4, 2016. A consent to the funding source was not dated and did not indicate whether a copy was offered to the client.

Client #13 was admitted on February 9, 2016. Consents dated 2/9/2016 to the funding source, client's PCP and a pharmacy did not indicate that a copy was offered to the client.

Client #23 was admitted on February 10, 2016. Consents dated 2/10/2016 to the funding source, a pharmacy, and legal agencies did not indicate that a copy was offered to the client.

These findings were reviewed with facility staff during the licensing process.

709.32 (c) (2) LICENSURE Medication control

§ 709.32. Medication control. (c) The project shall have and implement a written policy and procedures regarding all medications used by clients which shall include, but not be limited to: (2) Drug storage areas including, but not limited to, the secure storage of controlled substances and other abusable drugs in accordance with State and Federal regulations and program requirements.

Observations

Based on the physical plant inspection of the inpatient rehab nursing station on June 21, 2016, the facility did not secure controlled substances per state and federal requirements.

Several sets of facility keys along with a charging device were observed in the double-locked narcotic drawer in the nursing cart along with the controlled substances.

These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The nursing staff will be educated/ reeducated on this regulation in the nurses meeting on 7-27-16 by the Director of Nursing. The Director of nursing will also send the information out in an email to nursing staff by 7-27-16.

There is currently nothing other than medications in the Drug storage areas. The Director of nursing or designee will do a check of all medication areas once a month for 6 months to ensure compliance.

709.82(a) LICENSURE Treatment and rehabilitation services

709.82. Treatment and rehabilitation services. (a) An individual treatment and rehabilitation plan shall be developed with a client. This plan shall include, but not be limited to, written documentation of:

Observations

Based on a review of eight client records on June 20-21, 2016, four client records did not contain an individual treatment and rehabilitation plan developed with the client for the partial hospitalization program.

Client #11 was admitted April 4, 2016 and was discharged April 10, 2016 without a plan developed during the intake process.

Client #13 was admitted February 9, 2016 and discharged March 10, 2016 without a plan being developed during the intake process.

Plan of Correction

The new partial counselor will be trained on the required timeframe to complete an individualized treatment plan. The Clinical Supervisor will review the clinical binder 2x/month to ensure this standard is met.

Client #14 was admitted on January 18, 2016 and was discharged on February 13, 2016 without a plan being developed during the intake process.

Client #15 was admitted December 4, 2015 and was discharged January 1, 2016 without a plan being developed during the intake process.

These findings were reviewed with facility staff during the licensing process.

709.82(c) LICENSURE Treatment and rehabilitation services

709.82. Treatment and rehabilitation services. (c) The project shall assure that counseling services are provided according to the individual treatment and rehabilitation plan.

Observations

Based on a review of eight client records on June 20-21, 2016, four clients did not receive their individual treatment according to their treatment plans for the partial hospitalization program.

Client #8 was admitted on June 8, 2016 and is still an active client. The client was to receive individual counseling sessions once per week and was not seen for individual treatment prior to the date of inspection.

Client #9 was admitted on June 1, 2016 and is still an active client. The client was to receive individual counseling sessions once per week and was only seen on 6/8/16 prior to the date of inspection.

Client #10 was admitted on June 3, 2016 and is still an active client. The client was to receive individual counseling sessions once per week and was only seen on 6/16/16 prior to the date of inspection.

Client #14 was admitted on January 18, 2016 and was discharged on February 13, 2016. The client was to receive individual counseling sessions once per week and was not seen for individual treatment prior to discharge.

These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The new partial counselor will be trained on the required documentation and standard for individual counseling session.

The Clinical Supervisor will review the clinical binder 2x/month to ensure compliance with this regulation.

709.83(a) LICENSURE Client records

709.83. Client records. (a) There shall be a complete client record on an individual which includes information relative to the client's involvement with the project. This shall include, but not be limited to the following:

Observations

Based on a review of eight client records on June 21-22, 2016, the facility failed to ensure that a complete record was documented in three of eight records reviewed for the partial hospitalization program.

Client # 13 was admitted on February 9, 2016 and discharged on March 10, 2016. A record of service was not documented in the client's record, although there were progress notes for therapy sessions received by the client. Also, a preliminary treatment plan was missing.

Client #15 was admitted on December 4, 2015 and discharged on January 1, 2016. A record of service was not documented in the client's record, although there were progress notes for therapy session received by the client.

These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The Clinical Staff will be re-trained on the required Record of Service documentation. The Clinical Supervisors will review the clinical binders 2x/month to ensure compliance.

Upon discharge, the Medical Records staff will also review the chart to ensure the Record of Service was completed.

715.14(a) LICENSURE Urine testing

(a) A narcotic treatment program shall complete an initial drug-screening urinalysis for each prospective patient and a random urinalysis at least monthly thereafter.

Observations

Seven patient records were reviewed on June 20-22, 2016 for documentation of initial drug- screening urinalysis at the time of admission or re-admission. The facility failed to document when the urine test was collected in patient record # 4 and # 7.

Client #4 was admitted on January 4, 2016 and dosed on January 6, 2015. A urine test was completed but the facility failed to document the date the urine test was administered.

Client #7 was admitted on May 9, 2016 and dosed on May 10, 2016. A urine test was completed but the facility failed to document the date the urine test was administered.

These findings were reviewed with facility staff during the licensing process.

Plan of Correction

All new clients will receive a drug-screening urinalysis. Prior to all clients being dosed the results of the drug screen urinalysis need to be available. A copy of the results will be filed by the dosing nurse in the chart. The Director of Nursing will educate the dosing nurses on this individually by 7-29-16. The Director of Nursing will also add it to the methadone daily checklist that gets completed by the doing nurse and spot check 10 charts per month to ensure compliance.

Also, the UDS results were obtained for Client #4 on January 5, 2016 and on May 10, 2016 for Client #7. Both UDS reports are available in the patient records at this time.

709.52(c) LICENSURE Provision of Counseling Services

709.52. Treatment and rehabilitation services. (c) The project shall assure that counseling services are provided according to the individual treatment and rehabilitation plan.

Observations

Based on a review of eight client records on June 20-21, 2016, two clients did not receive their individual treatment according to their treatment plans for the inpatient program.

Client #16 was admitted on June 1, 2016 and is still an active client. The client was to receive individual counseling sessions once per week and was only seen on 6/7/16 prior to the date of inspection.

Client #18 was admitted on May 31, 2016 and is still an active client. The client was to receive individual counseling sessions once per week and was not seen for individual treatment prior to the date of inspection.

These findings were reviewed with facility staff during the licensing process.

Plan of Correction

The counseling staff will be re-trained on the required documentation of one individual session per week.

The Clinical Supervisor will review the clinical binders 2x/month to ensure compliance.

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BGI OF BRANDYWINE, INC

1375 NEWARK ROAD
KENNETT SQUARE, PA 19348

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Survey conducted on 11/29/2016

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on November 29, 2016 by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site complaint investigation, BGI of Brandywine, Inc. was found to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. Therefore, no deficiencies were identified during this investigation and no plan of correction is required.

Plan of Correction

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KENNETT SQUARE, PA 19348

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Survey conducted on 03/23/2017

INITIAL COMMENTS

This report is a result of a complaint investigation conducted on March 23, by staff from the Division of Accountability and Program Improvement. Based on the findings of the complaint investigation, the allegations against BGI of Brandywine, Inc.were partially substantiated. However, no areas of noncompliance with the applicable chapters of 28 PA Code which pertain to the facility were identified during this investigation; therefore, no plan of correction is required.

Plan of Correction

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1375 NEWARK ROAD
KENNETT SQUARE, PA 19348

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Survey conducted on 05/17/2017

INITIAL COMMENTS

This report is a result of an on-site complaint investigation conducted on May 17, 2017 by staff from the Division Accountability and Program Improvement. Based on the findings of the on-site complaint investigation, BGI of Brandywine, Inc was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility.

Plan of Correction

705.9 (1) LICENSURE General safety and emergency procedures.
705.9. General safety and emergency procedures. The residential facility shall: (1) Be free of rodent and insect infestation.

Observations
A physical plant inspection was conducted on May 17, 2017. Based on this inspection, the facility failed to be free from rodent infestation as there was rodent excrement observed in the dining area and the kitchen pantry of the Main Building. In addition, rodent excrement was observed in a client bedroom on the second floor of the Mansion.

Plan of Correction
Ehrlich, a pest control company, initially placed rodent stations in strategic locations around the affected buildings (Motel and Mansion) on 5/8. On 5/22 during a follow up visit, rodent activity was noted in the stations and bait replaced. On 5/24 more bait stations were added due to continued activity. On 6/12, Ehrlich found no activity in several interior bait stations. They did replace bait in a few external stations. Ehrlich will continue to monitor every 2 weeks. In addition, on 5/22 we added an announcement to our daily resident community meeting regarding no food in the rooms and our tech staff has been more assertive in removing food from the resident rooms during daily room inspections. All of these efforts appear to be working as we haven't heard of a mice complaint in several weeks. The tech supervisor will continue to monitor that staff are removing food from resident rooms daily during inspection by performing a spot check weekly.

709.52(d) LICENSURE Regularity of counseling provided
709.52. Treatment and rehabilitation services. (d) Counseling shall be provided to a client on a regular and scheduled basis.

Observations
A review of client files was conducted on May 17, 2017. Based on this review, the facility failed to provide counseling to clients on a regular and scheduled basis.

Client #1 was admitted April 28, 2017. The treatment plan, dated May 04, 2017 indicated that individual counseling was provided "as needed."

Client #2 was admitted May 06, 2017. The treatment plan May 06, 2017 indicated that individual counseling was provided "as needed."

Plan of Correction
On 5/23 the Clinical Supervisors conducted a training regarding the "as needed" language for individual counseling. The expectation is that treatment plans reflect individual counseling a minimum of 1x/week. This will be monitored during weekly chart audits conducted by the Clinical Supervisors.

In an interview with facility staff it was indicated that individual sessions are to be conducted once a week and not "as needed".

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Inspection Results

Surveys don't appear on this website until at least 41 days have elapsed since the exit date of the survey.

BGI OF BRANDYWINE, INC
1375 NEWARK ROAD
KENNETT SQUARE, PA 19348

Inspection Results Overview Definitions Surveys Additional Services Search

Survey conducted on 07/20/2017

INITIAL COMMENTS

This report is a result of an on-site licensure renewal inspection conducted on July 18-20, 2017, by staff from the Division of Drug and Alcohol Program Licensure. Based on the findings of the on-site inspection,BGI of Brandywine, Inc. was found not to be in compliance with the applicable chapters of 28 PA Code which pertain to the facility. The following deficiencies were identified during this inspection:

Plan of Correction

704.12(a)(1)(i) LICENSURE Client/couns ratios

704.12. Full-time equivalent (FTE) maximum client/staff and client/counselor ratios. (a) General requirements. Projects shall be required to comply with the client/staff and client/counselor ratios in paragraphs (1)-(6) during primary care hours. These ratios refer to the total number of clients being treated including clients with diagnoses other than drug and alcohol addiction served in other facets of the project. Family units may be counted as one client. (1) Inpatient nonhospital detoxification (residential detoxification). (i) There shall be one FTE primary care staff person available for every seven clients during primary care hours.

Observations

Based on a review of the Staffing Requirement Facility Summary Report (SRFSR) during the presubmission process and site licensing review on July 18-20, 2017, the facility failed to ensure one FTE primary care staff person available for every seven clients during primary care hours..

The daily census for 06/03/2017, was 37 patients, requiring a minimum of 6 primary care staff persons, but there were only 5 primary care staff persons working during the following hours:

12:00AM to 7:00AM

3:00PM to 11:00PM.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

Our current Detox staff schedule reflects a 1 to 7 staff to client ratio for up to 35 detox clients. The Admissions Director will be notified when our detox census is at 35. Prior to any additional detox admissions, the Admissions Director will notify the DON to ensure we have enough primary care staff available to go above 35 in detox. We will only go above 35 in detox if we have available staff to ensure a 1 to 7 ratio. The Nursing Supervisor will complete a random audit of the detox census vs the staff schedule monthly to ensure that this regulation is being met. The Nursing Supervisor will report her findings to the DON.

715.20(3) LICENSURE Patient transfers

A narcotic treatment program shall develop written transfer policies and procedures which shall require that the narcotic treatment program transfer a patient to another narcotic treatment program for continued maintenance, detoxification or another treatment activity within 7 days of the request of the patient. (3) The transferring narcotic treatment program shall document what materials were sent to the receiving narcotic treatment program.

Observations

Based on a review of 18 patient records on July 20, 2017, the facility failed to document what information was released to the receiving narcotic treatment program in one of one record reviewed, #17.

Patient #17 was admitted for narcotic treatment on 4/12/2017, and was transferred to a narcotic treatment program on 05/09/2017.

These findings were reviewed with facility staff as part of the inspection process.

Plan of Correction

A protocol for transferring patients to an NTP was written. Staff will utilize an NTP transfer sheet to document what information was released to the receiving NTP and once completed will become part of the patient's record. The DON and Nursing Supervisor will train the nurse's via a nursing meeting and email prior to 9/1/17. The DON will complete quarterly chart audits to ensure this regulation is being followed.

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