

Department of Human Services
Bureau of Human Service Licensing

November 5, 2020

PAUL COCO, ADMINISTRATOR
WELLTOWER OPCO GROUP LLC
7902 WESTPARK DRIVE
ATTN - MENERVA PHILSON
MCLEAN, VA 22102

RE: SUNRISE OF LAFAYETTE HILL
429 RIDGE PIKE
LAFAYETTE HILL, PA, 19444
LICENSE/COC#: 14324

Dear Mr. Coco,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 09/10/2020, 09/11/2020, 09/14/2020, 09/15/2020 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Shawn Parker

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *SUNRISE OF LAFAYETTE HILL* License #: *14324* License Expiration Date: *12/15/2020*
 Address: *429 RIDGE PIKE, LAFAYETTE HILL, PA 19444*
 County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: *Dawn Harrington* Phone: *6109403888* Email:
LafayetteHill.RCD@sunriseseniorliving.com;
shparker@pa.gov

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*
 Address: *7902 WESTPARK DRIVE, ATTN - MENERVA PHILSON, MCLEAN, VA, 22102*
 Phone: *6109403888* Email: *LICENSING@SUNRISESENIORLIVING.COM*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *100* Waking Staff: *75*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint* Exit Conference Date: *09/15/2020*

Inspection Dates and Department Representative

09/10/2020 - Off-Site: Alexander Goldstein
09/11/2020 - Off-Site: Alexander Goldstein
09/14/2020 - Off-Site: Alexander Goldstein
09/15/2020 - Off-Site: Alexander Goldstein

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *105* Residents Served: *66*

Secured Dementia Care Unit

In Home: *Yes* Area: *0* Capacity: *25* Residents Served: *20*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *66*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *34* Have Physical Disability: *1*

Inspections / Reviews

09/10/2020 - Partial

Lead Inspector: *Alexander Goldstein*Follow-Up Type: *POC Submission*Follow-Up Date: *10/14/2020*

11/5/2020 - POC Submission

Lead Reviewer: *Shawn Parker*Follow-Up Type: *Document Submission*Follow-Up Date: *11/16/2020*

42b - Abuse

1. Requirements

2600.

- 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 8/10/2020, Staff member A reported to the med care manager, Staff member B, that resident #1 expressed pain in her left leg before being transferred into bed. Resident #1's Medication Administration Record (MAR), shows that Staff member B administered Resident #1 PRN Acetaminophen at 6:24pm but no assessment was done on the residents leg. The way resident #1 injured her leg was undetermined. On 8/11/2020 at 6:14am, Staff member C reported that resident #1 was again expressing pain in her left leg and that the left leg was swollen while attempting to get the resident dressed. It was not until 11:05am on 8/11/2020 that resident #1's leg was assessed by a nurse, Staff Member D. At that point the home notified Resident #1's doctor and an x-ray was ordered. Upon receiving the x-ray results it was determined that resident #1 had a fractured left ankle. On 8/12/2020 resident #1 was sent to Chestnut Hill hospital.

Plan of Correction**Accept**

On 8/10/20, staff member A informed staff member B that resident #1 was experiencing pain. Resident #1 who has history of pain was administered a PRN medication for pain relief by staff member B. Staff member B later documented that the pain medication was effective. On 8/11/20, the resident was assessed by a licensed nurse, physician was notified, and an x-ray was ordered. Upon receiving results of x-ray, resident #1 was sent to hospital for treatment. 8/12/20

The Executive Director and Resident Care Director will conduct training for current direct care staff persons on responding to pain and the facility's pain management program 10/31/20.

The Resident Care Director will conduct a random audit of resident records after an occurrence of pain is documented by staff members to ensure the facility's pain management program was followed 10/31 through 1/31/20

The POC including training progress will be discussed and evaluated (for up to 3 months) to verify any new staff members have received training by the Executive Director and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again 10/28/20 and ongoing.

Completion Date: 10/10/2020