



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: June 16, 2021

[REDACTED]
Authorized Person
Welltower OPCO Group LLC
ATTN: [REDACTED]
7902 Westpark Drive
McLean, Virginia 22102

RE: Sunrise of Paoli
324 West Lancaster Avenue
Malvern, Pennsylvania 19355
License #: 143251

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections December 10, 2020 and April 8, 2021 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (143250) dated December 15, 2020 to December 15, 2021 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated December 15, 2020 to December 15, 2021 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from June 16, 2021 to December 16, 2021.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

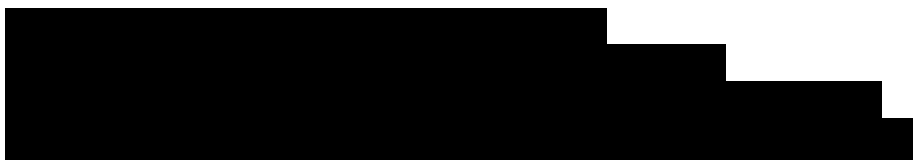
Sincerely,



Jamie Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
License
Licensing Inspection Summary

cc:



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

Facility Information

Name: *SUNRISE OF PAOLI* License #: *14325* License Expiration Date: *12/15/2020*
Address: *324 WEST LANCASTER AVENUE, MALVERN, PA 19355*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: *6102519994* Email: [REDACTED]

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*
Address: *7902 WESTPARK DRIVE, ATTN - [REDACTED], MCLEAN, VA, 22102*
Phone: *6102519994* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/02/1998* Issued By: *COPA L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *77* Waking Staff: *58*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *12/18/2020*

Inspection Dates and Department Representative

12/10/2020 - Off-Site: [REDACTED]
12/11/2020 - Off-Site: [REDACTED]
12/15/2020 - Off-Site: [REDACTED]
12/16/2020 - Off-Site: [REDACTED]
12/18/2020 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *110* Residents Served: *52*

Secured Dementia Care Unit

In Home: *Yes* Area: *Reminiscence* Capacity: *25* Residents Served: *16*

Hospice

Current Residents: *0*

Resident Demographic Data as of Inspection Dates (*continued*)

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 52

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 25

Have Physical Disability: 0

Inspections / Reviews

12/10/2020 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *01/29/2021*

3/24/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *03/29/2021*

4/21/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

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

Resident #1 was subject to neglect due to a deprivation of services necessary to maintain physical health when CPR was withheld by staff. At approximately 3:00am on [REDACTED], resident #1 was found to be unresponsive, without a pulse. Staff person A and B, who are certified in CPR, did not provide CPR to resident #1 in accordance with their training, the homes medical emergency policy and procedures and instruction by their supervisor and the 911 operator.

Resident #1 does not have a DNR order on file. Staff Person C, who is not CPR certified and who initially observed resident #1 to be unresponsive, informed CPR certified staff person A. Both Staff person A and C, went into resident #1's room, checked to see if resident was unresponsive, then left room and informed CPR Certified Staff Person B. Staff persons A, B, and C, then re-entered the resident room, checked to see that resident was unresponsive, then all three staff persons left the residents room to go to the nurses station. As reported by staff A and B, no staff person began CPR on the resident in accordance with the homes policy. Staff person C, then called their supervisor, who informed the staff to call 911 and have someone begin CPR on resident and continue until EMS arrived on site. Staff person C then called 911. 911 operator also advised that CPR be started on resident and continue until EMS arrived on site. Staff person A, B, and C then returned to the resident room but again, did not perform CPR on resident. EMS arrived onsite at approximately 3:32am and staff informed them that CPR had not been provided to the resident at any time.

Plan of Correction

Accept

Executive Director reviewed Abuse and Neglect with all team members including deprivation of services to ensure staff understanding.

The Executive Director will schedule training for team members with a representative from the Department of Aging on Abuse/Neglect.

Abuse and Abuse/Neglect Reporting Requirements (including OAPSA) training will continue to be completed upon hire and annually for all team members.

The Department Coordinators/Manager on Duty/Staff members will continue to report any suspected abuse immediately to AAA and the Executive Director. Incidents are reviewed for negative trends/problems that need to be addressed during the monthly Quality Management (Quality Assurance and Improvement Planning/QAPI) meeting. The POC including training progress will be discussed and evaluated (for up to 3 months) by the Executive Director and Coordinators at the 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 violation does not occur again.

Completion Date: 03/22/2021 Licensee's Proposed Date for POC Implementation

SP 05-24-2021

Document Submission

Not Implemented

see supporting documents

63d - Certified CPR Staff

1. Requirements

2600.

63.d. A staff person who is trained in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with his training, unless the resident has a do not resuscitate order.

63d - Certified CPR Staff (continued)

Description of Violation

On [REDACTED], resident #1 became unresponsive and was observed by staff persons to be without respiration or pulse. Staff persons A and B who are certified in obstructed airway techniques and CPR were present and on duty at the time and failed to render assistance to the resident in accordance with his/her training. Staff members were advised by a supervisor, and a 911 responder to begin CPR.

Plan of Correction

Accept

Immediately following incident Executive Director met with staff persons A and B, staff persons were trained on the CPR policy as well as the need to respond to a resident when observed without pulse and/or respirations. CPR policy clarified with all staff persons, CPR policy currently reads that CPR can be withheld if infectious disease is present (resident positive for COVID 19 at time of death)
On 11/13/20 Executive Director held training with all overnight care staff regarding CPR policy and responding to resident emergencies.
All staff persons trained on CPR policy/procedures and need to respond to residents who do not have a do not resuscitate order and are observed without pulse/respirations.
Training to continue to be reviewed with all new hires as part of new hire orientation.
The POC including training progress will be discussed and evaluated (for up to 3 months) by the Executive Director and Coordinators at the 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 violation does not occur again.

Completion Date: 03/22/2021 Licensee's Proposed Date for POC Implementation

SP 05-24-2021

Document Submission

Implemented

see supporting documents

143a - Emergency Medical Plan

1. Requirements

2600.

143.a. The home shall have a written emergency medical plan that includes the following:

143a - Emergency Medical Plan (continued)

Description of Violation

The homes written emergency medical plan has a specific section regarding responding to medical emergencies and includes a separate CPR policy that outlines the steps for responding to an unresponsive resident and performing CPR. The CPR policy reads: It is the policy of the community that a resident, who is found unresponsive, without a pulse and does not have a Do Not Resuscitate Order (DNR), will have CPR initiated by a team member certified in CPR unless it is determined by a healthcare professional, acting within the established scope of practice, that obvious clinical signs of death are present. The policy further outlines the steps to be taken and reads:

Section 1- a resident who is found unresponsive, without a pulse, the Team Member will:

- a. Validate the residents code status
- b. If the resident does not have a DNR order
 - i. Call/have another team member call Emergency Services (911)
 - ii. The CPR Certified team member will start CPR
 - iii. Utilize AED if present on site
 - iv. Continue CPR until emergency services arrive and assumes care for the resident

Staff did not properly follow the policy set forth by the homes Medical Emergencies Policy on [REDACTED]. At approximately 3:00am on [REDACTED], resident 1 was found to be unresponsive, without a pulse. Resident 1 does not have a DNR order on file. Staff Person C, who is not CPR certified and who initially observed resident 1 to be unresponsive, informed staff person A, who is CPR certified. Both Staff person A and C, when into resident 1's room, checked to see if resident was unresponsive, then left room and informed Staff Person B, who is also CPR certified. Staff persons A, B, and C, then re-entered the resident room again, checked to see that resident was unresponsive, then all three left the room to go to the nurses station. As reported by staff A and B, no staff person began CPR on the resident. Staff person C, then called their supervisor, who informed the staff to call 911 and have someone begin CPR on resident and continue until EMS arrived on site. Staff person C then called 911. 911 operator also advised that CPR be started on resident and continue until EMS arrived on site. Staff person A, B, and C then returned to the resident room but did not perform CPR on resident. EMS arrived onsite and staff informed them that CPR had not been provided to the resident at any time.

Plan of Correction

Accept

Immediately following incident Executive Director met with staff persons A B and C, staff persons were trained on the CPR policy as well as emergency preparedness and responding to emergencies.

On 11/13/20 Executive Director held training with all overnight care staff regarding responding to resident emergencies.

All staff persons trained on CPR policy/procedures and need to respond to residents who do not have a do not resuscitate as well as managing emergency situations.

Training to continue to be reviewed with all new hires as part of new hire orientation.

The POC including training progress will be discussed and evaluated (for up to 3 months) by the Executive Director and Coordinators at the 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 violation does not occur again.

Completion Date: 03/22/2021 Licensee's Proposed Date for POC Implementation

SP 05-24-2021

Document Submission

Not Implemented

see supporting documents

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

Facility Information

Name: *SUNRISE OF PAOLI* License #: *14325* License Expiration Date: *12/15/2021*
Address: *324 WEST LANCASTER AVENUE, MALVERN, PA 19355*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: *6102519994* Email: [REDACTED]

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*
Address: *7902 WESTPARK DRIVE, ATTN - [REDACTED], MCLEAN, VA, 22102*
Phone: *6102519994* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/02/1998* Issued By: *COPA L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *78* Waking Staff: *59*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Monitoring, Interim* Exit Conference Date: *04/08/2021*

Inspection Dates and Department Representative

04/08/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *110* Residents Served: *48*

Secured Dementia Care Unit

In Home: *Yes* Area: *Reminiscence* Capacity: *25* Residents Served: *16*

Hospice

Current Residents: *-*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *48*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *30* Have Physical Disability: *0*

Inspections / Reviews

04/08/2021 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/30/2021*

5/19/2021 - POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *05/24/2021*

5/24/2021 - Document Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Not Required*

65a - FS Orientation 1st Day

1. Requirements

2600.

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

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

Description of Violation

The following staff persons did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

- *Staff person A, whose first day of work was [REDACTED]*
- *Staff person B, whose first day of work was [REDACTED]*
- *Staff person C whose first day of work was [REDACTED]*
- *Staff person D, whose first day of work was [REDACTED]*

65a - FS Orientation 1st Day (continued)

Plan of Correction**Accept**

Staff Member A has not worked in the community since 3/31/21. Orientation in general fire safety and emergency preparedness (as per regulation 2600.65a) will be completed immediately upon their next shift worked. At this time, Staff Member A does not have any upcoming shift scheduled.

Staff Member B: Orientation in general fire safety and emergency preparedness was completed on their next working day in the community, 4/16/21.

Staff Member C: Orientation in general fire safety and emergency preparedness was completed on their next working day in the community, 4/21/21.

Staff Member D: Orientation in general fire safety and emergency preparedness was completed on their next working day in the community, 4/14/21.

The ED along with the RCC and the MC, manages the planning of agency staff persons Orientation in general fire safety and emergency preparedness to be provided prior to or during the first workday. When a new agency staff member arrives for their first day of work in the community, either the ED, the RCC or MC will conduct orientation immediately upon their arrival. In the event a new agency staff member arrives for a last-minute shift overnight, a Lead Care Manager will conduct the orientation immediately upon their arrival.

Lead Care Managers will be trained on conducting Agency Orientation as a backup to a Coordinator.

ED will discuss new agency team members daily with RCC and coordinate the plan for timely orientation, including assigning a coordinator or team member to conduct orientation at that time. ED will monitor agency compliance binder daily.

The POC monitoring will be reviewed and evaluated by the Executive Director, Resident Care Coordinator and Maintenance Coordinator through the Quality Assurance and Improvement Program monthly, for up to 3 months or until agency is no longer being utilized in the community.

Completion Date: 05/18/2021 Licensee's Proposed Date for POC Implementation

SP 05-24-2021

Implemented

65a - FS Orientation 1st Day (continued)

Document Submission**Implemented**

Staff Member A has not worked in the community since 3/31/21. Orientation in general fire safety and emergency preparedness (as per regulation 2600.65a) will be completed immediately upon their next shift worked. At this time, Staff Member A does not have any upcoming shifts scheduled.

Staff Member B: Orientation in general fire safety and emergency preparedness was completed on their next working day, 4/16/21.

Staff Member C: Orientation in general fire safety and emergency preparedness was completed on their next working day, 4/21/21.

Staff Member D: Orientation in general fire safety and emergency preparedness was completed on their next working day, 4/14/21.

Lead Care Managers were trained on conducting agency orientation on general fire safety, emergency preparedness, resident rights, abuse and neglect, and incident reporting on 5/5/21.

Quality Assurance and Improvement Program was conducted on 5/18/21 in which the leadership team was trained on conducting agency orientation on general fire safety, emergency preparedness, resident rights, abuse and neglect, incident reporting and all required training as per regulation 2600.65a. The POC will be reviewed monthly at the QAPI meetings through July 2021 or until agency is no longer being utilized in the community.

65b - Rights/Abuse 40 Hours

1. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

The following staff persons did not complete training in the following topics on or before their 40th hour worked at the home: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

- *Staff person A, who completed their 40th scheduled work hour on or before 3/31/21*
- *Staff person B, who completed their 40th scheduled work hour on or before 4/5/21*
- *Staff person C who completed their 40th scheduled work hour on or before 4/5/21*
- *Staff person D, who completed their 40th scheduled work hour on or before 3/25/21*

65b - Rights/Abuse 40 Hours (continued)

Plan of Correction**Accept**

Staff Member A has not worked in the community since 3/31/21. Orientation which includes training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions (as per regulation 2600.65b) will be completed immediately upon their next shift worked. At this time, Staff Member A does not have any upcoming shift scheduled.

Staff Member B: Orientation which included training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions was completed on their next working day in the community, 4/16/21.

Staff Member C: Orientation which included training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions was completed on their next working day in the community, 4/21/21.

Staff Member D: Orientation which included training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions was completed on their next working day in the community, 4/14/21.

The ED along with the RCC and the MC, manages the planning of agency staff persons Orientation which includes training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions, to be provided on or before their 40th hour worked. When a new agency staff member arrives for their first day of work in the community, either the ED, the RCC or MC will conduct orientation immediately upon their arrival. In the event a new agency staff member arrives for a last-minute shift overnight, a Lead Care Manager will conduct the orientation immediately upon their arrival.

Lead Care Managers will be trained on conducting Agency Orientation as a backup to a Coordinator.

ED will discuss new agency team members daily with RCC and coordinate the plan for timely orientation, including assigning a coordinator or team member to conduct orientation at that time. ED will monitor agency compliance binder daily.

The POC monitoring will be reviewed and evaluated by the Executive Director, Resident Care Coordinator and Maintenance Coordinator through the Quality Assurance and Improvement Program monthly, for up to 3 months or until agency is no longer being utilized in the community.

Completion Date: 05/18/2021 Licensee's Proposed Date for POC Implementation

SP 05-24-2021

Implemented

65b - Rights/Abuse 40 Hours *(continued)***Document Submission****Implemented**

Staff Member A has not worked in the community since 3/31/21. Orientation which includes training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions (as per regulation 2600.65b) will be completed immediately upon their next shift worked. At this time, Staff Member A does not have any upcoming shift scheduled.

Staff Member B: Orientation which included training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions was completed on their next working day in the community, 4/16/21.

Staff Member C: Orientation which included training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions was completed on their next working day in the community, 4/21/21.

Staff Member D: Orientation which included training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions was completed on their next working day in the community, 4/14/21.

Lead Care Managers were trained on conducting agency orientation on general fire safety, emergency preparedness, resident rights, abuse and neglect, and incident reporting on 5/5/21.

Quality Assurance and Improvement Program was conducted on 5/18/21 in which the leadership team was trained on conducting agency orientation on general fire safety, emergency preparedness, resident rights, abuse and neglect, incident reporting and all required training as per regulation 2600.65b. The POC will be reviewed monthly at the QAPI meetings through July 2021 or until agency is no longer being utilized in the community.