



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [REDACTED]

September 9, 2022

[REDACTED]  
[REDACTED]  
Welltower OpCo Group, LLC  
[REDACTED]  
[REDACTED]

RE: Sunrise at Lafayette Hill  
429 Ridge Pike  
Lafayette Hill, Pennsylvania 19444  
License #: 14324

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 1, 2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

[REDACTED]

[REDACTED]  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

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

**Facility Information**

**Name:** SUNRISE OF LAFAYETTE HILL      **License #:** 14324      **License Expiration Date:** 12/15/2022  
**Address:** 429 RIDGE PIKE, LAFAYETTE HILL, PA 19444  
**County:** MONTGOMERY      **Region:** SOUTHEAST

**Administrator**

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

**Legal Entity**

**Name:** WELLTOWER OPCO GROUP LLC  
**Address:** [REDACTED]  
**Phone:** [REDACTED]      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** I-2      **Date:** 06/18/1998      **Issued By:** whitemarsh twp

**Staffing Hours**

**Resident Support Staff:** 0      **Total Daily Staff:** 65      **Working Staff:** 49

**Inspection**

**Type:** Partial      **Notice:** Unannounced      **BHA Docket #:**  
**Reason:** Incident      **Exit Conference Date:** 10/01/2021

**Inspection Dates and Department Representative**

10/01/2021 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 105      **Residents Served:** 55

**Secured Dementia Care Unit**

**In Home:** Yes      **Area:** Reminiscence      **Capacity:** 25      **Residents Served:** 10

**Hospice**

**Current Residents:** 4

**Number of Residents Who:**

**Receive Supplemental Security Income:** 0      **Are 60 Year of Age or Older:** 50  
**Diagnosed with Mental Illness:** 1      **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 10      **Have Physical Disability:** 1

**Inspections / Reviews**

10/01/2021 Partial

**Lead Inspector:** [REDACTED]      **Follow-Up Type:** POC Submission      **Follow-Up Date:** 11/04/2021

Inspections / Reviews *(continued)*

11/5/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow Up Type: *Document Submission*

Follow-Up Date: *11/08/2021*

## 15a - Resident Abuse Report

### 1. Requirements

2600.

- 15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

### Description of Violation

On [REDACTED]/21 at approximately [REDACTED] am, resident 1 requested medication. Staff A threatened the resident stating "Don't press that pendant again." The home did not report this allegation of abuse in accordance with the OAPSA.

### Plan of Correction

Accept

The Executive Director to contact Area Agency on Aging to report allegation of abuse in accordance with OAPSA reporting requirements. The facility had reported to Department of Human Services on [REDACTED] as alleged violation of the resident's rights.

The Executive Director and the Personal Care Coordinator met with staff A; the staff was educated on residents' rights and abuse.

The Executive Director provided training on resident rights and abuse reporting procedures at the monthly Town Hall Meeting.

The Executive Director or designee will conduct daily meeting and discuss any incidents that occurred which would need to be reported to DHS or to AAA in accordance with OAPSA reporting procedures.

The POC and monitoring results are reviewed and evaluated by the Executive at the monthly Quality Assurance and Performance Improvement (Quality Management) meeting for 3 months to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

**Completion Date:** 11/04/2021 Licensee's Proposed Date of POC Implementation

Implemented 9/9/22

## 15b - Supervisor Plan

### 1. Requirements

2600.

- 15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

### Description of Violation

On [REDACTED] 21 at approx. [REDACTED] AM, Staff A threatened resident 1. The home did suspend Staff A nor develop and submit a plan of supervision to the AAA and the Department in accordance with the OAPSA.

## 15b - Supervisor Plan (continued)

**Plan of Correction****Accept**

On 11/4/21, the Director of Operations provided education and training to the Executive Director (ED) on the requirement to place staff members on administrative upon receiving an allegation of abuse or resident rights violation, as the incident was reported to DHS as an allegation of a resident rights violation.

The Executive Director will provide education and training to Resident Care Director (RCD), Personal Care Coordinator (PCC), and Reminiscence Coordinator (RC) on requirement to place staff members on administrative leave upon receiving an allegation of abuse or an alleged violation of resident rights.

The POC and monitoring results are reviewed and evaluated by the Executive at the monthly Quality Assurance and Performance Improvement (Quality Management) meeting for 3 months to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

**Completion Date:** 11/04/2021 Licensee's Proposed Date of POC Implementation

Implemented 9/9/22

## 42c - Treatment of Residents

**1. Requirements**

2600.

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

**Description of Repeat Violation**

On [REDACTED]/21 at approximately [REDACTED] AM, Resident 1 stated that a request was made through a call bell for pain medication. Staff A came to the resident's room and displayed an angry demeanor. Staff A questioned resident's request for medication, saying "You don't look like you need morphine." Resident 1 stated that staff A waived a finger inches away from the resident 1's face. Resident 1 stated that Staff A also told the resident "Don't press that button again". The resident expressed fear of Staff A.

Repeated Violation: 12/23/2020

**Plan of Correction****Accept**

The Executive Director and the Personal Care Coordinator conducted an investigation regarding the alleged incident with staff person A; the staff was educated and retrained on residents' rights including treating residents with respect and dignity.

The Personal Care Coordinator conducted training with medication care managers on the proper process and response to a resident who is requesting an as needed medication for pain management.

The Executive Director provided training on resident rights and abuse reporting to all staff members at the monthly Town Hall Meeting.

The POC and monitoring results are reviewed and evaluated by the Executive at the monthly Quality Assurance and Performance Improvement (Quality Management) meeting for 3 months to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

**Completion Date:** 11/04/2021 Licensee's Proposed Date of POC Implementation

Implemented 9/9/22