Department of Human Services
Bureau of Human Service Licensing

August 16, 2022

[redacted]
HCRI SUN III TENANT LP
[redacted]

RE: SUNRISE SENIOR LIVING OF DRESHER
1650 SUSQUEHANNA ROAD
DRESHER, PA, 19025
LICENSE/COC#: 12841

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 07/27/2022 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,
Mia Johnson

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *SUNRISE SENIOR LIVING OF DRESHER* **License #**: *12841* **License Expiration**: *03/06/2023*

Address: *1650 SUSQUEHANNA ROAD, DRESHER, PA 19025*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *2152831123* **Email**: [redacted]

Legal Entity

Name: *HCRI SUN III TENANT LP*

Address: *7902 WESTPARK DRIVE, ATTN LICENSING, MCLEAN, VA, 22102*

Phone: *2152831123* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/15/2006* **Issued By**: *Township of Upper Dublin*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *97* **Waking Staff**: *73*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *07/27/2022*

Inspection Dates and Department Representative

07/27/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *105* **Residents Served**: *61*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *reminiscense* **Capacity**: *30* **Residents Served**: *14*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *58*

Diagnosed with Mental Illness: *2*

Diagnosed with Intellectual Disability: *3*

Have Mobility Need: *36*

Have Physical Disability: *0*

Inspections / Reviews

07/27/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/12/2022*

08/16/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/18/2022*

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 [redacted] at approximately 1:20 am, staff person A observed bruising on resident 1's face around [redacted] left eye, down [redacted] face through [redacted] neck area and [redacted] right arm. Staff person A reported the bruising to staff person B as [redacted] believed that staff person B was the lead caregiver. Staff person B stated "it looks old". No care was given to resident 1 at that time and the bruising on resident 1 was disregarded. Staff person A reported the bruising again around 6:00 am to staff person C who is the lead caregiver for the morning shift. Staff person C did not respond to staff person A, as [redacted] was having a disagreement with staff person B.

At approximately 9:00 am, staff person D was asked by staff person E to assist resident 1 to breakfast. While staff person D was assisting resident 1 to breakfast they observed the bruising and reported it to staff person E. The resident was assessed by staff person F and sent for breakfast. After breakfast the resident began to vomit blood. Staff person C then called staff person F to send the resident out to the hospital via ambulance. The resident was diagnosed with a T-12 compression fracture.

Plan of Correction ***Accept***

[redacted] *The resident was assessed by wellness nurse and transferred to the emergency room for further evaluation.*

9-3-2022 The Resident Care Director (RCD) is providing education and training on steps to take if a discoloration is discovered on a resident. Staff members are to report skin issues/discolorations to wellness department for evaluation.

7-27-2022The Executive Director conducted a training with all staff persons on conducting proper cross over at the start of each shift and timely reporting of resident care concerns.

7-27-2022 and ongoing The leadership team will maintain daily communication with team members to ensure resident care concerns are assessed by the wellness department.

8-23-2022 The POC and monitoring process will be discussed during monthly QAPI meetings for 3 months. If not effective, it will be amended and new POC will be implemented and monitored to ensure incident does not occur again.
Completion Date: *09/30/2022*