Department of Human Services
Bureau of Human Service Licensing

December 1, 2022

[redacted]
WELLTOWER OPCO GROUP LLC
[redacted]

RE: SUNRISE OF NEWTOWN SQUARE
333 SOUTH NEWTOWN STREET ROAD
NEWTOWN SQUARE, PA, 19073
LICENSE/COC#: 14326

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/31/2022, 11/01/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *SUNRISE OF NEWTOWN SQUARE* **License #**: *14326* **License Expiration**: *12/15/2023*

Addre : *333 SOUTH NEWTOWN STREET ROAD, NEWTOWN SQUARE, PA 19073*

County: *DELAWARE* **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**: *01/20/2004* **Issued By**: *Township of Newtown*

Type: *C-2 LP* **Date**: *11/07/2002* **Issued By**: *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *105* **Waking Staff**: *79*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *11/01/2022*

Inspection Dates and Department Representative

10/31/2022 - On-Site: [redacted]

11/01/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served**: *65*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *26* **Residents Served**: *22*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *65*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *40*

Have Physical Disability: *0*

Inspections / Reviews

10/31/2022 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *11/18/2022*

11/18/2022 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *11/30/2022*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/01/2022*

12/01/2022 Document Submi ion

Submitted By: [redacted] **Date Submitted:** *11/30/2022*

Reviewer [redacted] **Follow Up Type:** *Not Required*

28e - Death of a Resident

1. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on [redacted]/21. Resident #1 s personal belongings were removed on from the room on [redacted]/21; however, the resident's refund was not processed until [redacted]/21.

Resident #2 passed away on [redacted]/21. Resident #2 s personal belongings were removed on from the room on [redacted]/21; however, the resident's refund was not processed until [redacted]/21.

Plan of Correction ***Accept [redacted] - 11/18/2022)***

[redacted]/21--Resident #1's refund was processed [redacted]2021.
[redacted]/21--Resident #2's refund was processed [redacted]/2021.
11/2/22--The Executive Director provided training to the Business Office Coordinator in-service on regulatory requirements for providing refunds to residents after discharge.
The Executive Director and Business Office Coordinator discuss discharges during the morning meeting. The Executive Director or designee provides the move out form to the Business Office Coordinator for processing. The Executive Director verifies the refund has been processed and approves for distribution to resident.
11/17/22--Start, This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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.
See Attachment A - In-service sheet

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented ([redacted] 12/01/2022)

65a - FS Orientation 1st Day

3. 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.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

Staff person A, whose first day of work was [redacted]/22, 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.

Plan of Correction ***Accept ([redacted] - 11/18/2022)***

[redacted]22--Staff person A is no longer employed with the community.
11/2/22--The Executive Director provided training to the Business Office Coordinator in-service on completing orientation in general fire safety and emergency preparedness with new employees.
11/30/22--The Executive Director and the Business Office Coordinator will audit personnel files by 11/30/2022 to verify staff persons have completed orientation in general fire safety and emergency preparedness.
11/2/22--Upon hire of a new employee the Business Office Coordinator will complete orientation in general fire safety and emergency preparedness and document completion of the training. The proof of training will be filed in the respective staff person personnel record.
11/8/22--The Executive Director will audit new employee records for the next 3 months to verify completion of the required orientation in general fire safety and emergency preparedness.
11/17/22--Start--This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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.
See Attachment A—in-service sheet

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented ([redacted] - 12/01/2022)

91 - Telephone Numbers

4. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in room [redacted]

Plan of Correction ***Accept ([redacted] 11/18/2022)***

11/1/22--The Executive Director posted the required emergency in numbers resident apartment [redacted] on [redacted]/22.
11/4/22--A check of telephones with an outside line was completed by the Executive Director to verify required emergency telephone numbers were posted on or by each telephone.
11/30/22--The Executive Director framed the required emergency telephone numbers, and the frames are being hung by telephones with an outside line in resident apartments.
11/30/22--The Executive Director or designee verifies that telephones with an outside line have the required

91 - Telephone Numbers (continued)

emergency telephones numbers posted on or by each telephone during the monthly rounds.
11/17/22--start--This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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.

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented (12/01/2022)

121a Unobstructed Egress

5. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On /22, at PM, a magnetic lock was in place on "Exit Stair A" blocking egress from the home's 3rd floor, personal care side.

Plan of Correction ***Accept 11/18/2022)***

11/2/22--The Maintenance Coordinator disengaged the magnetic lock on 11/2/2022.
11/2/22--When the manufacturer is servicing the doors, upon completion the Maintenance Coordinator or designee will verify before they leave that the locking mechanisms are working properly and not causing an obstruction.
11/2/22--The Maintenance Coordinator or designee verifies stairways, hallways, doorways, passageways and egress routes from rooms and from the building are not locked and are not obstructed during the monthly community walk thru.
11/17/22--start--This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented 12/01/2022)

132d - Evacuation

6. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety e pert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drills on 12/22/21, 01/19/22, 02/24/22 and 03/16/22, the home did not evacuate all residents to a

132d - Evacuation (continued)

public thoroughfare or to a fire safe area as designated by a fire safety expert.

Plan of Correction ***Accept (- 11/18/2022)***

3/31/22--In March 2022 it was self-identified that fire drills needed to be recorded to indicate evacuation of all residents to a public thoroughfare, or to a fire-safe area as designated in writing by the fire safety expert.
10/31/22--For the subsequent 7 fire drills; April 22, 2022, May 26, 2022, June 30, 2022, July 26, 2022, August 21, 2022, September 27, 2022, and October 28,2022 the Maintenance Coordinator has documented properly the evacuation of all residents to a public thoroughfare, or to a fire-safe area as designated in writing by the fire safety expert.
Fire drill from April 2022 through present reviewed by the surveyor at time of inspection and noted to be compliance with the regulation.
11/1/22--The Executive Director or designee monitors fire drill records monthly to verify the Maintenance Coordinator or designee has documented properly the evacuation of all residents to a public thoroughfare, or to a fire-safe area as designated in writing by the fire safety expert.
11/17/22--start, This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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

Licensee's Proposed Overall Completion Date: *11/18/2022*

Implemented (12/01/2022)

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's most recent medical evaluation was completed on /22. The resident's previous medical evaluation was completed on /20.

Plan of Correction ***Accept - 11/18/2022)***

11/2/22--Resident #3's DME was misfiled and found on /22 after the inspection.
11/30/22--The Resident Care Director is conducting an audit of resident records to 1verify each resident has a current medical evaluation form.
11/2/22--The Executive Director provided training to the Resident Care Director and wellness nurse on the requirement that residents need a medical evaluation form at least annually and proper filing of the medical evaluation forms.
11/2/22--The Resident Care Director uses the tickler from the electronic health record for prompting of obtaining the annual medical evaluations for residents.
11/7/22--The Executive Director will randomly review medical evaluations due and verify they are obtained timely for up to 3 months.
11/17/22--start, This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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.

141b1 - Annual Medical Evaluation (continued)

See Attachment B—in-service sheet

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented [redacted] - 12/01/2022)

224a Preadmission Screen Form

8. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department s preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #4 was admitted to the home on [redacted]21; however, the resident's preadmission screening form was completed on [redacted]/22.

Plan of Correction ***Accept ([redacted] - 11/18/2022)***

11/2/22--The Executive Director provided training on 11/2/2022 to the Resident Care Director and Wellness on the requirement of preadmission screening being completed within 30 days prior to admission.
11/30/22--The Resident Care Director and Wellness nurse will audit all resident records, by 11/30/2022, to verify each resident has the required preadmission screening.
11/1/22--Prior to a resident moving in the Resident Care Director or designee will complete a preadmission careening form.
11/7/22--The Executive Director or designee will review admissions documents during morning meeting to verify preadmission screening forms are completed timely for new admissions.
11/30/22--This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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
See Attachment B—in-service sheet

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented ([redacted] 12/01/2022)

225c Additional Assessment

9. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #5's assessment, dated [redacted]/22, does not include physician's assessment of mobility of "[redacted])" as listed on resident's DME dated [redacted]/22. Instead, the home's [redacted]/22 assessment lists the resident's mobility as "[redacted])".

225c - Additional Assessment (continued)

Resident #6's assessment, dated [redacted]/22, does not include physician's assessment of mobility of "[redacted])" as listed on resident's DME dated [redacted]/22. Instead, the home's [redacted]/22 assessment lists the resident's mobility as "[redacted])".

Plan of Correction ***Accept ([redacted] 11/18/2022)***

11/17/22--Residents #5 was reassessed and the updated to accurately capture the resident's mobility status and align with the physician's assessment of the resident's mobility.
11/17/22--Residents #6 was reassessed and the updated to accurately capture the resident's mobility status and align with the physician's assessment of the resident's mobility.
11/2/22--The Executive Director provided training on 11/2/2022 to the Resident Care Director on the requirement of reviewing the medical evaluation form when the resident is being assessed to properly document the resident's mobility status.
11/30/22--The Resident Care Director and Wellness nurse will audit all resident assessment, by 11/30/2022, to verify the resident mobility status as documented in the medical evaluation form aligns with what is documented in the assessment.
11/2/22--At time of assessing a resident the Resident Care Director or designee will review the medical evaluation form to properly document the resident's mobility status.

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented ([redacted] 12/01/2022)

231b - Medical Evaluation

10. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]21; however, the resident's medical evaluation, completed on [redacted]/22, does not indicate the need for the resident to be served in a secure dementia care unit.

Plan of Correction ***Accept ([redacted] - 11/18/2022)***

11/1/22--Resident #6's primary care physician completed a new medical evaluation form for the residents indicating the need for the resident to be served in a secured dementia care unit.
11/2/22--The Executive Director provided training to the Resident Care Director and wellness nurse on the requirement that the medical evaluation for a resident in the secured dementia care neighborhood should indicate the need
for the resident to be served in a secured dementia care unit.
11/30/22--The Resident Care Director and Wellness nurse will audit all resident in the secured dementia care neighborhood medical evaluation forms, by 11/30/2022, to verify each form indicates the need for the resident to be served in a secured dementia care unit.
11/2/22--Prior to a resident moving into the secured dementia care unit,
the Resident Care Director or designee review the medical evaluation form upon receipt to verify it indicates the need for the resident to be served in a secured dementia care unit.

231b - Medical Evaluation (continued)

11/7/22--The Executive Director or designee will review admissions documents during morning meeting to proper completion of the medical evaluation form.
11/17/22, start, This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED 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
See Attachment B—in-service sheet

Licensee's Proposed Overall Completion Date: *11/30/2022*

Implemented ([redacted] - 12/01/2022)