

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

February 29, 2024

[REDACTED]
WELLTOWER OPCO GROUP LLC
[REDACTED]
[REDACTED]

RE: SUNRISE OF UPPER ST. CLAIR
500 VILLAGE DRIVE
UPPER ST. CLAIR, PA, 15241
LICENSE/COC#: 44882

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/03/2024 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

Facility Information

Name: *SUNRISE OF UPPER ST. CLAIR* License #: *44882* License Expiration: *12/15/2024*
 Address: *500 VILLAGE DRIVE, UPPER ST. CLAIR, PA 15241*
 County: *ALLEGHENY* Region: *WESTERN*

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: *07/27/2005* Issued By: *Twp. of Upper St. Clair*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *114* Waking Staff: *86*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint, Incident* Exit Conference Date: *01/03/2024*

Inspection Dates and Department Representative

01/03/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *94* Residents Served: *76*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Memory care* Capacity: *39* Residents Served: *32*

Hospice
 Current Residents: *9*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *76*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *38* Have Physical Disability: *0*

Inspections / Reviews

01/03/2024 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/03/2024*

02/06/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *02/23/2024*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/09/2024*

Inspections / Reviews *(continued)*

02/14/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 02/23/2024

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 02/23/2024

02/29/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: 02/23/2024

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

Residents [redacted] and [redacted] reside in the Secured Dementia Care Unit (SDCU) of the home. Resident [redacted] is diagnosed with [redacted] with [redacted] and, according to records and staff interviews, has a history of physically aggressive behavior toward other residents and another resident's family member.

On [redacted] at approximately [redacted] staff person A observed resident [redacted] and resident [redacted] sitting next to each other, sleeping on a couch in the living room of the SDCU. About 35 minutes later, staff person B heard yelling and saw resident [redacted] hitting resident [redacted] on the back of [redacted] head and yelling "[redacted] [redacted]". Resident [redacted] was bleeding from [redacted] right arm and hand and resident [redacted] had blood around [redacted] mouth area. Resident [redacted] sustained a bite wound to [redacted] right hand that required 3 sutures, scratches on [redacted] arm, and was administered a [redacted] and a 7-day course of [redacted]. The home failed to adequately supervise resident [redacted], resulting in an injury to resident [redacted].

Plan of Correction

Accept [redacted] - 02/14/2024)

On [redacted] immediately following incident care managers from the direction of Resident Care Director removed and redirected resident [redacted] from all other residents and provided a safe secure area. Resident Care Director contacted the family immediately following the incident regarding the need for medication changes to better manage Resident [redacted] behaviors. [redacted] family meeting held to discuss medication changes and need for psychiatric evaluation. Resident [redacted] was immediately removed from the area of resident [redacted] and sent to the Emergency for further evaluation of injuries noted from resident [redacted]. The family of resident [redacted] contacted immediately regarding incident.

Beginning [redacted] weekly interdisciplinary team meetings are being held. During these meetings conducted by the Executive Director, or designee, department heads will discuss any residents currently having behavior changes as well as potential residents at risk for behavior changes. The RCD or designee will ensure residents are discussed and interventions are put in place, and or seen by primary care physician as needed.

On [redacted] an educational in service was provided and documented by the Resident Care Director and Commonwealth Hospice to all SDCU team members. The in-service included information on caring for residents with Dementia and how to identify aggressive behaviors in a dementia resident. Information also included how to provide a safe environment for all residents experiencing behavior changes. Documentation of education to be kept in POC Binder. On-going training for all new employees, quarterly training for all existing employees, and re-training for employees will be completed and documented.

Beginning [redacted] residents with existing and potential behaviors were discussed and changes were addressed if needed by RCD or designee. During interdisciplinary team meetings residents with potential behavior changes will continually be discussed and interventions implemented by RCD or Designee. RCD or Designee will be responsible for documenting and providing.

Resident [redacted] discussed, and interventions put in place for greater safety. During waking hours resident [redacted] to have 1 to 1 companion. Continued interventions and employees requiring training to be discussed at quarterly quality assurance meeting beginning [redacted]

Beginning 2/22/2024 The POC and monitoring results are reviewed and evaluated by the Executive Director and

42b - Abuse (continued)

coordinators at the quarterly Quality Assurance and Performance Improvement (Quality Management) meeting to ensure it is still effective for two consecutive Meetings. 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. In the event it is determined the home cannot meet the resident's needs, the home will consult with the resident's designated person and an appropriate assessment agency, if needed, to determine if the resident needs a higher level of care. If a higher level of care is needed, a plan shall be made as soon as possible.

Proposed Overall Completion Date: 03/22/2024

Licensee's Proposed Overall Completion Date: 03/22/2024

Implemented [REDACTED] - 02/29/2024)

225c - Additional Assessment

2. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [REDACTED] assessment, dated [REDACTED], indicates on [REDACTED], the resident threw a shoe at another resident and on [REDACTED], hit a resident in the shoulder. On [REDACTED] resident [REDACTED] bit the hand of resident [REDACTED] causing injury. However, the supervision needs indicate resident [REDACTED] only requires moderate supervision due to [REDACTED] wandering behavior and poor safety awareness and does not include the need for extensive supervision.

Plan of Correction

Accepted [REDACTED] - 02/06/2024)

On [REDACTED] immediately following incident, care managers from the direction of Resident Care Director removed and redirected resident [REDACTED] from all other residents and provided a safe secure area. Resident Care Director contacted the family immediately following the incident regarding the need for medication changes to better manage Resident [REDACTED] behaviors. [REDACTED] family meeting with Executive Director and Resident Care Director was held to discuss medication changes and need for psychiatric evaluation.

Beginning 1/30/2024 weekly interdisciplinary team meetings are being held. During these meetings conducted by the Executive Director, or designee, department heads will discuss any residents currently having behavior changes as well as potential residents at risk for behavior changes. The RCD or designee will ensure residents are discussed and interventions are put in place, and or seen by primary care physician as needed.

225c - Additional Assessment (continued)

On 1/31/2024 an education to be provided by the Executive Director to community Care Coordinators and Resident Care Director on residents assessed needs and additional assessments as it correlates to regulation 2600.225.c. Documentation of Education to be kept.

On 1/31/2024 an audit of accurate resident assessments and their needs to be completed by RCD or Designee for 5 residents weekly for 30 days. Documentation of audit to be kept.

Starting 2/22/2024 The POC and monitoring results are reviewed and evaluated by the Executive Director and coordinators at the quarterly Quality Assurance and Performance Improvement (Quality Management) meeting to ensure it is still effective for two consecutive meetings. 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.

Licensee's Proposed Overall Completion Date: 03/22/2024

Implemented [REDACTED] - 02/29/2024)