

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

March 7, 2024

[REDACTED], SENIOR EXECUTIVE DIRECTOR  
MS LOWER MAKEFIELD SH LLC

RE: SUNRISE SENIOR LIVING OF LOWER  
MAKEFIELD  
631 STONY HILL ROAD  
YARDLEY, PA, 19067  
LICENSE/COC#: 13809

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/17/2024, 01/18/2024 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 SENIOR LIVING OF LOWER MAKEFIELD      **License #:** 13809      **License Expiration:** 08/13/2024  
**Address:** 631 STONY HILL ROAD, YARDLEY, PA 19067  
**County:** BUCKS      **Region:** SOUTHEAST

## Administrator

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

## Legal Entity

**Name:** MS LOWER MAKEFIELD SH LLC

**Address:** [REDACTED]

## Certificate(s) of Occupancy

**Type:** I-2      **Date:** 07/16/2008      **Issued By:** Lower Makefield Township

## Staffing Hours

**Resident Support Staff:** 0      **Total Daily Staff:** 102      **Waking Staff:** 77

## Inspection Information

**Type:** Full      **Notice:** Unannounced      **BHA Docket #:**  
**Reason:** Renewal, Incident      **Exit Conference Date:** 01/18/2024

## Inspection Dates and Department Representative

01/17/2024 - On-Site: [REDACTED]  
01/18/2024 - On-Site: [REDACTED]

## Resident Demographic Data as of Inspection Dates

## General Information

**License Capacity:** 95      **Residents Served:** 71

## Secured Dementia Care Unit

**In Home:** Yes      **Area:** Reminiscence Unit      **Capacity:** 29      **Residents Served:** 15

## Hospice

**Current Residents:** 4

## Number of Residents Who:

**Receive Supplemental Security Income:** 1      **Are 60 Years of Age or Older:** 71  
**Diagnosed with Mental Illness:** 0      **Diagnosed with Intellectual Disability:** 2  
**Have Mobility Need:** 31      **Have Physical Disability:** 0

## Inspections / Reviews

01/17/2024 Full

**Lead Inspector:** [REDACTED]      **Follow-Up Type:** POC Submission      **Follow-Up Date:** 02/13/2024

02/20/2024 - POC Submission

**Submitted By:** [REDACTED]      **Date Submitted:** 03/01/2024  
**Reviewer:** [REDACTED]      **Follow-Up Type:** Document Submission      **Follow-Up Date:** 03/01/2024

Inspections / Reviews *(continued)*

03/07/2024 Document Submission

Submitted: [REDACTED]

Date Submitted: 03/01/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

## 15c - Supervision

## 1. Requirements

2600.

15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

## Description of Violation

On [REDACTED] at approximately [REDACTED] staff member A noticed resident #1 was holding [REDACTED] left shoulder. When asked what had happened, resident #1 stated "that black boy punched me". Management identified the staff person as staff member B. This incident was reported to staff person C immediately on [REDACTED]. Staff person B was placed on administrative leave but returned to work on [REDACTED] and worked through [REDACTED] without an approved plan of supervision.

## Plan of Correction

Accept [REDACTED] - 02/20/2024)

Staff member B was terminated effective 12/15/23.

ED in-serviced community leaders on 1/20/24 requirement of approved plan of supervision prior to any team members returning to work and immediately submitting to the department's regional office a request for an approved supervision.

ED/ Designee will review alleged abuse/ neglect allegations for team members placed on administrative leave to determine if submitting a plan of supervision to the department is appropriate. If appropriate, ED/ Designee will submit plan of supervision and wait for approval prior to team member returning to work.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [REDACTED] - 03/07/2024)

## 16c - Written Incident Report

## 2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

## Description of Violation

16c Written Incident Report (continued)

On [REDACTED], at approximately [REDACTED], staff member A noticed resident #1 was holding [REDACTED] left shoulder. When asked what had happened, resident #1 stated "that black boy punched me". Management identified the staff person as staff member B. This incident was reported to staff person C immediately on [REDACTED]. Staff person B was placed on administrative leave but returned to work on [REDACTED] and worked through [REDACTED] without an approved plan of supervision. The home did not report this incident to the department until [REDACTED] at [REDACTED].

Repeat Violation: 08/01/22.

Plan of Correction

Accept [REDACTED] - 02/20/2024)

ED submitted incident report to DHS on 12/8/23 and AAA on 12/8/23.

ED met with leadership team on 1/20/24 to review reporting requirements of reportable events including requirement to report all events within 24 hours. ED reviewed reporting requirements with community team members on 1/31/24.

ED/ Designee will review all incidents/ reportable events to ensure they are reported timely.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [REDACTED] - 03/07/2024)

28e - Death of a Resident

3. 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 #2 passed away on [REDACTED]. Resident #2's personal belongings were removed from their room on [REDACTED]; however, as of [REDACTED], resident #2 has not been issued a refund of [REDACTED], per request dated [REDACTED] by staff member C, in accordance with the Elder Care Payment Restitution Act.

Plan of Correction

Accept [REDACTED] - 02/20/2024)

Community processed refund for resident #2 on [REDACTED] and check was cashed on 1/29/24.

28e - Death of a Resident (continued)

ED educated Business Office Coordinator on 1/20/24 on requirement to issue resident refunds within 30 days of discharge. Business Office Coordinator audited all move outs for the previous 90 days to ensure all refunds have been issued on 2/1/24.

BOC/ ED will review all move outs weekly to ensure refunds are processed timely.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [REDACTED] - 03/07/2024)

65a - FS Orientation 1st Day

4. 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

- Staff person B, whose first day of work was [REDACTED], 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.

65a FS Orientation 1st Day (continued)

Staff person D, whose first day of work was [REDACTED] 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] - 02/20/2024)

Effective 1/22/24 team members are no longer employed with Sunrise Senior Living.

ED educated BOC & coordinators to complete PCH orientation upon onboarding for all new hires and Team Members will not provide care until training are completed on 1/20/24.

Business Office Coordinator completed audit of all TM files to ensure PCH training has been completed for all team members on 2/9/24.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [REDACTED] - 03/07/2024)

65b - Rights/Abuse 40 Hours

5. 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

Staff person B completed his/her 40th scheduled work hour on [REDACTED]. However, this staff person did not complete training in the following topics: 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 D completed his/her 40th scheduled work hour in November 2023. However, this staff person did not

65b - Rights/Abuse 40 Hours (continued)

complete training in the following topics: 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.

Plan of Correction

Accept ( [redacted] ) - 02/20/2024)

Effective 1/22/24 team members are no longer employed with Sunrise Senior Living.

Business office Coordinator completed audit of all TM files to ensure compliance with training on 2/9/24.

BOC/ Designee will ensure Resident rights, Mandatory reporting Abuse/ neglect, emergency medical plan and reporting of reportable incidents is completed by the team member's 40th hour worked, or the team member will be removed from the schedule until training is completed.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented ( [redacted] ) - 03/07/2024)

65f - Training Topics

6. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person E did not receive training in the following topics during training year 2023:

- instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan,
- safe management techniques.

65f - Training Topics (continued)

**Plan of Correction**

Accept ( [redacted] ) - 02/20/2024)

ED/ Designee will educate team member on meeting the needs as described in the preadmission screening form, assessment tool, medical evaluation, and support plan on 2/15/24.

ED/ Designee will complete audit all current team member files by 2/20/24 to ensure team members have received all required trainings in accordance with 65f.

ED/ Designee will educate staff on 2/27/24 on meeting the needs as described in the preadmission screening form, assessment tool, medical evaluation, and support plan.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented ( [redacted] ) - 03/07/2024)

65g - Annual Training Content

**7. Requirements**

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

**Description of Violation**

Staff person F did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert during training year 2023.

**Plan of Correction**

Accept ( [redacted] ) - 02/20/2024)

Team Member will be educated upon return from maternity leave.

ED/ Designee will complete audit all current team member files by

65g Annual Training Content (continued)

2/27/24 to ensure team members have received all required training in accordance with regulation 65g.

ED/ Designee will educate team members on 2/20/24 on annual trainings as required per regulation 65g.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [redacted] 03/07/2024)

82c - Locking Poisonous Materials

8. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A tube of [redacted] toothpaste, with a manufacture's label indicating "Keep out of reach of children. If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away.", was unlocked, unattended, and accessible to residents in room 128. Not all the residents of the home, including residents in the Reminiscence Unit (secured dementia care unit), have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [redacted] - 02/20/2024)

Maintenance Coordinator immediately repaired locked drawer on 1/19/24.

All resident apartments were audited on 2/1/24 to ensure locking drawer for poisonous materials to be secured.

ED/ Designee educated leadership team and staff on 1/31/24 importance of securing poisonous materials and conducting weekly walk throughs to ensure all poisonous materials are secured.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

82c Locking Poisonous Materials (continued)

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented (████) - 03/07/2024)

85a - Sanitary Conditions

9. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 01/18/24 at 2:09 PM, a soiled piece of toilet paper was found on the outside of the toilet bowl in the public restroom by the dining room.

Plan of Correction

Accept (████) - 02/20/2024)

Housekeeping staff cleaned and sanitized the bathroom immediately after finding.

Maintenance Coordinator conducted walkthrough of community on 1/19/24 to ensure sanitary conditions were met throughout community.

ED/ Designee educated team members on 1/31/24 on importance of maintaining sanitary conditions of all resident areas and if an unsanitary condition is observed, report to housekeeping team immediately.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented (████) - 03/07/2024)

85e - Trash Outside Home

10. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 01/18/24 at 12:06 PM, the outside dumpsters were not covered with attached lids.

Plan of Correction

Accept (████) - 02/20/2024)

The Maintenance Coordinator immediately closed the dumpster lids.

ED/ Designee educated team members on 1/31/24 on importance of ensuring the dumpster lid remains closed, if open, it shall be closed

85e Trash Outside Home (continued)

immediately.

Maintenance Coordinator/ Designee will ensure dumpster lid remains closed.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented ( ) - 03/07/2024)

101j7 - Lighting/Operable Lamp

11. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #3 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept ( ) - 02/20/2024)

Portable lamp was placed in apartment of resident #3.

All resident apartments were audited on 2/1/24 to ensure all residents had access to a working lamp within reach.

ED/ Designee educated team members on 1/31/24 the requirement for residents to have a lamp within reach and conducting walkthroughs to ensure a lamp is within reach, if not, report immediately.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented ( ) - 03/07/2024)

132a - Monthly Fire Drill

12. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

Unannounced fire drills were not held during the months of January, April, June and December 2023.

Plan of Correction

Accept ( [redacted] - 02/20/2024)

Community completed monthly fire drill on January 31, 2024.

Maintenance Coordinator educated by ED on 1/20/24 on regulatory requirement to complete monthly fire drills 132a.

ED/ Designee will monitor fire drill compliance monthly to ensure compliance.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [redacted] - 03/07/2024)

132e - Fire Drill Sleeping Hours

13. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 07/19/23 at 6:10 AM. The previous sleeping hours fire drill was conducted on 12/14/22 at 12:21 AM.

Plan of Correction

Accept [redacted] - 02/20/2024)

Last sleeping hours fire drill completed on 7/19/23.

Next sleeping hours fire drill will be completed by February 19, 2024.

Maintenance Coordinator educated by ED on 1/20/24 on regulatory requirement to complete a fire drill during sleeping hours every 6 months.

ED/ Designee will monitor compliance Q 6 months X 1 year.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be

132e - Fire Drill Sleeping Hours (continued)

implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented (████) - 03/07/2024)

185a - Implement Storage Procedures

14. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 01/18/24, a loose pill was found in the second drawer and another in the third drawer of the second-floor medication cart referred to as "Cart A & E".

Plan of Correction

Accept (████) - 02/20/2024)

Loose pills were immediately removed from the medication cart.

RCD/ Sr. RCD audited all medication carts to ensure no additional loose pills were found on 1/19/24.

RCD/ Designee educated Medication Care Managers on identifying loose pills in medication carts, removing them immediately and reporting to RCD on 1/31/24.

RCD/ Designee will complete medication cart audits monthly and the ED/ Designee will evaluate results monthly X 3 months.

On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented (████) - 03/07/2024)

227g -Support Plan Signatures

15. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The support plan (SEHA) signature pages for residents' 4, 5, and 6 are signed but are not dated by any of the signing parties, resident or staff.

227g -Support Plan Signatures (*continued*)**Plan of Correction****Accept** [REDACTED] - 02/20/2024)

*ED/ Designee will conduct an audit to ensure all support plans are signed and dated.*

*ED educated coordinators on requirement for support plans to be reviewed with the resident and responsible party within 30 days of admission to the home, 30 days within completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment and shall be signed and dated on 1/20/24.*

*ED/ Designee will review all support plan documents to ensure compliance monthly X 3 months.*

*On 2/28/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.*

**Licensee's Proposed Overall Completion Date: 08/28/2024**

**Implemented** [REDACTED] - 03/07/2024)