

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

April 10, 2024

[REDACTED], REGIONAL DIRECTOR OF OPERATIONS
WELLTOWER OPCO GROUP LLC
[REDACTED]
[REDACTED]

RE: SUNRISE OF NORTH WALES
1419 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14806

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/31/2024, 02/01/2024 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 NORTH WALES **License #:** 14806 **License Expiration:** 11/04/2023
Address: 1419 HORSHAM ROAD, NORTH WALES, PA 19454
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: WELLTOWER OPCO GROUP LLC
Address: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 12/21/2012 **Issued By:** Horsham Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 99 **Waking Staff:** 74

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 02/01/2024

Inspection Dates and Department Representative

01/31/2024 - On-Site: [REDACTED]
02/01/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 92 **Residents Served:** 67

Secured Dementia Care Unit

In Home: Yes **Area:** Reminiscence **Capacity:** 58 **Residents Served:** 22

Hospice

Current Residents: 13

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 67
Diagnosed with Mental Illness: 2 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 32 **Have Physical Disability:** 0

Inspections / Reviews

01/31/2024 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 02/23/2024

Inspections / Reviews (*continued*)

02/28/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/05/2024

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 03/01/2024

03/01/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/05/2024

[REDACTED] [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/05/2024

04/10/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/05/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

34 Pa.Code Chapter 3, known as the Boilers and Unfired Pressure Vessels regulations. (governed by Department of Labor and Industry). If a home has a boiler, it must have a valid "Certificate of Boiler or Pressure Vessel Operation" issued by the PA Department of Labor and Industry. Upon expiration of the certificate, boilers must be inspected, and if they pass inspection, they will be issued a new certificate. On 01/31/2024, the home did not have a current boiler certificate on file.

Plan of Correction

Accept [redacted] - 02/28/2024)

On 2/1/2024 Executive Director (ED) and Senior Maintenance Coordinator (Sr. MC) attempted to locate boiler certificate. Sr. MC scheduled for boiler inspection 2/6/2024.

On 2/6/2024 Boiler passed inspection and community is awaiting certificate.

On 2/1/2024 ED educated MC to ensure the boiler certificate remains current and is inspected timely.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented [redacted] - 03/13/2024)

65e - 12 Hours Annual Training

2. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A completed 2022 annual training on 03/06/2023 when the annual training for training years ending in 2022 should have been completed by January 31, 2023.

Plan of Correction

Accept [redacted] - 02/28/2024)

On 2/5/2024 direct care staff person A in question has completed annual training and is currently in compliance.

On 2/5/2024 ED and BOC audited current team member trainings to ensure we are in compliance.

On 2/29/2024 and ongoing ED to review with department coordinators outstanding trainings for the current month by the middle of the month. ED and department coordinators are to then review the outstanding trainings for the current month at the end of the month to ensure completion.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

65e - 12 Hours Annual Training (continued)

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented (████) - 03/13/2024)

82c - Locking Poisonous Materials

3. 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

On 02/01/2024 around 10:30 AM, the cabinet under the bathroom sink in resident room #307 with a container of Clorox disinfecting wipes, Crest toothpaste, and other personal hygiene items was unlocked, unattended, and accessible to residents. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept (████) - 02/28/2024)

On 2/1/2024 ED immediately locked cabinet to ensure poisonous materials were secured.

On 2/1/2024 Personal Care Coordinator (PCC) walked through all rooms and common areas in the secured dementia unit to ensure that all poisonous materials were secure. All cabinets were locked, and poisonous materials were secured. Upon walk through all locks were found in good working order.

On 2/5/2024 ED educated PCC and all frontline staff on walking through secured dementia unit routinely to ensure all poisonous materials are secured.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented (████) - 04/10/2024)

87 - Lighting

4. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The home has six exit doors on the 1st floor. Except for the main entrance, the other five exit doors are equipped with a delayed locking system. However, there was no sign/notice 'PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15-20 SECONDS' posted on the door.

87 Lighting (continued)

Plan of Correction

Accept (redacted) - 02/28/2024)

On 1/31/2024 ED immediately hung signage, "In case of emergency press and hold door for 20 seconds".

On 1/31/2024 ED walked through community and posted signs on all exit doors.

On 2/27/2024 ED to educate all team members that if they see a door without sign to notify MC immediately and a sign will be placed.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented (redacted) - 04/10/2024)

102h - Toilet Paper

5. Requirements

2600.

102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 02/01/2024 at 10:00 AM, there was no toilet paper for the toilet in the bathroom of resident room #123.

Plan of Correction

Accept (redacted) - 02/28/2024)

On 2/1/2024 ED immediately replaced toilet paper in room 123.

On 2/1/2024 PCC conducted walk through of all rooms to ensure that all rooms had toilet paper.

On 2/5/2024 ED educated housekeepers and direct care staff on replacing toilet paper in resident rooms.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented (redacted) - 04/10/2024)

102i - Soap Dispenser

6. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was an unlabeled used bar of soap in the shower stall and two unlabeled used bars of soap on the bathroom

102i Soap Dispenser (continued)

sink in the bathroom of resident room #123. The bathroom is shared by two residents.

Plan of Correction

Accept ([redacted]) - 02/28/2024)

On 2/1/2024 Personal Care Coordinator (PCC) immediately labeled soap dish. ED ordered soap dishes to have on supply.

On 2/1/2024 PCC did a room audit of all shared rooms to ensure that all bathrooms were labeled appropriately.

On 2/5/2024 ED educated PCC and direct care staff to label all shared resident rooms upon move into the community and throughout residents stay.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented (CM - 04/10/2024)

103g - Storing Food

7. Requirements

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There was an opened and unsealed bag of cereal in one of the cupboards in the home's Buckingham dining room.

Repeat Violation: 11/15/2022 et al

Plan of Correction

Accept ([redacted]) - 02/28/2024)

On 2/1/2024 ED immediately disposed of cereal.

On 2/1/2024 PCC inspected all cabinets in the Buckingham dining room to ensure that all food is in a closed or sealed container.

On 2/5/2024 ED provided education for team members on ensuring the food is properly sealed and dated.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented ([redacted]) - 04/10/2024)

121a - Unobstructed Egress

8. Requirements

121a - Unobstructed Egress (continued)

2600.

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

Description of Violation

The home has six exit doors on the 1st floor. Except for the main entrance, the other five exit doors are equipped with a delayed locking device with a key pad. On 01/31/2024 around 10:30 AM, there was no code posted near the key pad, nor was a sign with instructions for the operation of the door present.

Plan of Correction

Accept (████) - 02/28/2024)

On 1/31/2024 ED immediately posted codes on each exit door and stairwell door.

On 1/31/2024 ED walked through community and posted codes on all exit doors.

On 2/27/2024 ED to educate all team members that if they see a door without sign to notify MC immediately and code will be posted.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented (████) - 04/10/2024)

121b - Locking Device Approval

9. Requirements

2600.

121.b. Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the home has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Description of Violation

The home has six exit doors on the 1st floor. Except for the main entrance, the other five exit doors are equipped with a delayed locking device, preventing immediate egress. The home does not have written approval or a variance from the Department of Labor and Industry, the Department of Health or the local building authority for use of this delayed egress system.

Plan of Correction

Accept (████) - 02/29/2024)

On 2/1/2024 ED attempted to locate written approval from Department of Labor and Industry.

On 2/22/2024 all exit doors on the first floor have been unlocked from the inside allowing immediate egress.

On 2/27/2024 ED to educate all team members that if they notice a first floor door does not have immediate egress to notify MC immediately to correct.

The POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter one and two 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.

121b - Locking Device Approval (continued)

Proposed Overall Completion Date: 02/29/2024

Licensee's Proposed Overall Completion Date: 02/29/2024

Implemented (█) - 03/13/2024

132h - Designated Meeting Place

10. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 10/27/2023 at 02:03 PM, there were 68 residents present in the home but only 26 residents evacuated to a fire safety area.

Plan of Correction

Accept (█) - 02/28/2024

On 2/5/2024 ED reeducated Maintenance Assistant (MA) on fire drill documentation to ensure the head count includes all individuals in the building and not just those evacuating the fire zone.

On 2/5/2024 Reviewed prior fire drills and all drills have been documented properly.

On 2/5/2024 ED and MC will complete February and March logs together to ensure that the documentation is completed properly.

The Plan of Corrections (POC) and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI/ Quality Management) meeting for quarter one and two 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.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented (█) - 04/10/2024