

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

April 9, 2024

[REDACTED], REGIONAL DIRECTOR OF OPERATIONS
SZR ABINGTON AL OPCO LLC
[REDACTED]
[REDACTED]

RE: SUNRISE OF ABINGTON
1841 SUSQUEHANNA ROAD
ABINGTON, PA, 19001
LICENSE/COC#: 14488

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/11/2024, 03/12/2024 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 ABINGTON* License #: *14488* License Expiration: *01/01/2025*
Address: *1841 SUSQUEHANNA ROAD, ABINGTON, PA 19001*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SZR ABINGTON AL OPCO LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *12/07/2000* Issued By: *Abington Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *104* Waking Staff: *78*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *03/12/2024*

Inspection Dates and Department Representative

03/11/2024 - On-Site: [REDACTED]
03/12/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	<i>110</i>	Residents Served:	<i>62</i>
Secured Dementia Care Unit			
In Home:	<i>Yes</i>	Area:	<i>Reminence</i>
Capacity:	<i>28</i>	Residents Served:	<i>11</i>
Hospice			
Current Residents:	<i>2</i>		
Number of Residents Who:			
Receive Supplemental Security Income:	<i>0</i>	Are 60 Years of Age or Older:	<i>62</i>
Diagnosed with Mental Illness:	<i>0</i>	Diagnosed with Intellectual Disability:	<i>0</i>
Have Mobility Need:	<i>42</i>	Have Physical Disability:	<i>2</i>

Inspections / Reviews

03/11/2024 Full
Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/06/2024*

Inspections / Reviews *(continued)*

04/09/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/09/2024

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document Submission*

04/09/2024 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/09/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

- 17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 3/11/2024, the resident face sheet binders were unlocked, unattended, and accessible at the receptionist desk in a cart.

Plan of Correction

Accept (████) - 04/09/2024)

On 3/11/2024, the Executive Director (ED) immediately secured the resident face sheet binder in the locked cabinet at the front desk.

On 3/12/2024, the Assistant Executive Director (AED) and ED conducted an in-service with all concierge staff on the importance of keeping the resident face sheet binder locked in the cabinet at the front desk as it pertains to confidentiality.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of keeping resident records confidential and inaccessible especially at the front desk.

On 4/11/2024 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (████) - 04/09/2024)

18 - Compliance With Laws

2. 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

CARE FACILITY CARBON MONOXIDE ALARMS STANDARDS ACT - ENACTMENT Act of Jun. 23, 2016 Carbon monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

On 3/11/2024, there was no carbon monoxide detector located near the fossil fuel burning stove in the kitchen. It had been removed and never replaced.

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785). On 3/11/2024, the home did not have an influenza poster anywhere.

Plan of Correction

Accept (████) - 04/09/2024)

On 3/11/2024, the Director of Environmental Services (DES) immediately installed a carbon monoxide detector

18 Compliance With Laws (continued)

near the fossil fuel burning stove in the kitchen.

On 3/11/2024, the ED immediately posted the influenza information poster at the front desk as required by the Influenza Awareness Act (HB 1785).

On 3/12/2024, the DES conducted a walk through of the community to ensure all carbon monoxide detectors were installed and in working order. No additional concerns identified.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the Applicable Health and Safety Laws Care Facility Carbon Monoxide Alarms Standards Act and Influenza Awareness Act (HB 1785).

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Proposed Overall Completion Date: 04/15/2024

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (████) - 04/09/2024)

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.

Description of Violation

Staff person A, whose first day of work was ██████████, 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.

Plan of Correction

Accept (████) - 04/09/2024)

On 3/14/2024, Staff Person A received an orientation by the ED and DES on the evacuation, transportation and emergency procedures, staff duties and responsibilities during fire drills, the designated meeting place outside the

65a - FS Orientation 1st Day (continued)

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 and the location and use of fire extinguishers.

On 3/19/2024, the ED conducted an audit of all team member files in the business office to ensure team members received an orientation in general fire safety and emergency preparedness. No additional concerns identified.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the orientation requirements for new team members regarding general fire safety and emergency preparedness.

On 4/15/2024, the ED or Business Office Coordinator (BOC) will bring all new hire files to the weekly leadership meeting to verify there is a proper orientation of general fire safety and emergency preparedness.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024)

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/11/2024, stairwell leading up to the maintenance area and 3rd floor of the home had dark stains on the carpets.

On 3/11/2024, the ice maker in kitchen has a buildup of a black substance in the ice area.

Plan of Correction

Accept (█) - 04/09/2024)

On 3/11/2024, the Director of Dining Services (DDS) immediately cleaned the ice maker in kitchen that had a buildup of a black substance in the ice area.

On 3/11/2024, the DES immediately cleaned and shampooed the dark stains on the carpets in the stairwell leading up to the maintenance area and 3rd floor.

On 3/11/2024, the DES conducted a walkthrough immediately of all stairwells and carpets to check for any other darks stains. No additional concerns identified.

On 3/13/2024, ED and DES provided an in-service on sanitation as it pertains to the community and stairwell areas to the maintenance and housekeeping staff.

On 3/14/2024, ED and DDS provided an in-service on sanitation as it pertains to the kitchen and ice machine cleanliness to the culinary staff.

On 3/17/2024 and ongoing, The DDS will conduct random checks on a weekly basis of the kitchen to verify that

85a - Sanitary Conditions (continued)

the ice machine is clean and free of any buildup.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of maintaining sanitation in the kitchen, stairwells and overall, in the community.

On 4/11/2024 and ongoing, the DES will clean and shampoo the stairwells quarterly to ensure cleanliness and sanitation are being maintained.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024)

88a - Surfaces

5. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 3/11/2024, wall on second floor has an opening with wire exposed from a thermostat that is missing.

On 3/11/2024, there was a can of Glade Air Freshener unattended in the memory care bathroom which is a hazard.

Plan of Correction

Accept (█) - 04/09/2024)

On 3/11/2024, the DES immediately installed a plate cover on the wall on the second floor to cover the opening that had exposed wire from a missing thermostat.

On 3/11/2024, the DES immediately removed and disposed of a can of Glade Air Freshener that was unattended in the memory care bathroom.

On 3/11/2024, the Reminiscence Coordinator (RC) immediately conducted a walk through in the Memory Care Neighborhood to verify that there were no other chemicals unsecured. No additional concerns identified.

On 3/12/2024, the DES conducted a walkthrough of the community to ensure that there were no other openings in the walls with a missing thermostat. No additional concerns identified.

On 3/14/2024, the Reminiscence Coordinator (RC) conducted an in-service with the memory care team members on all surfaces and areas to be free of hazards.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance that all floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be

88a - Surfaces (continued)

amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024)

95 - Furniture and Equipment

6. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/11/2024, at 9:33 am, there is a light blinking with its cover on the floor in the stairwell.

On 3/11/2024, in room 110 the kitchen cabinet door was falling off.

On 3/11/2024, in Room 223 the kitchen cabinet door was falling off.

On 3/11/2024, in Room 320 the kitchen cabinet door was falling off.

On 3/11/2024, in Room 324 the kitchen cabinet door was falling off.

Plan of Correction

Accept (█) - 04/09/2024)

On 3/11/2024, the DES immediately replaced the light bulb and installed the cover on the light that was blinking in the stairwell.

On 3/11/2024, the DES immediately repaired the kitchen cabinet doors in apartments: 110, 223, 320 and 324.

On 3/12/2024, the DES walked all resident and vacant apartments in Personal Care and Reminiscence to ensure the cabinet doors were not falling off. No additional concerns identified.

On 3/12/2024, the DES replaced all light bulbs and light covers in all stairwells of the community.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance that all furniture and equipment must be in good repair, clean and free of hazards.

On 4/11/2024 and ongoing, the DES will conduct a walkthrough of the stairwells quarterly to ensure all lights are not blinking and the covers are properly installed.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

95 - Furniture and Equipment (continued)

Proposed Overall Completion Date: 04/15/2024

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024)

101j1 - Mattress Fire Retardant

7. Requirements

2600.

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

- 1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 3/11/2024, resident 1 has a mattress that has the factory plastic still covering the mattress.

Plan of Correction

Accept (█) - 04/09/2024)

On 3/14/2024, the Personal Care Coordinator (PCC) removed the factory plastic cover from Resident 1's bed and replaced it with a fire-retardant mattress cover.

On 3/14/2024, the PCC conducted a walkthrough and inspected all resident beds to ensure they had a fire-retardant mattress cover, and all were in good repair. No additional concerns identified.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of resident beds having a fire-retardant mattress cover in good repair.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024)

103c - Food Protected

8. Requirements

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 3/11/2024, there was an open bottle of lemon juice that states to be refrigerated after opening in the dry storage area.

Plan of Correction

Accept (█) - 04/09/2024)

On 3/11/2024, the DDS immediately disposed of the open bottle of lemon juice in the dry storage that should have been refrigerated after it was opened and conducted a walk through in the kitchen to verify all items that needed to be refrigerator was not left out. No additional concerns identified.

103c Food Protected (continued)

On 3/14/2024, the DDS provided an in service on the importance of food being protected from contamination while being stored, prepared, transported and served.

On 3/17/2024 and ongoing, The DDS will conduct random checks on a weekly basis of the kitchen to verify that food is covered and protected from contamination while being stored, prepared transported or served.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of food being protected from contamination while being stored, prepared, transported and served.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (████) - 04/09/2024)

103g - Storing Food

9. Requirements

- 2600.
- 103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The Edy's Ice Cream in the ice cream freezer was opened and unsealed.

Plan of Correction

Accept (████) - 04/09/2024)

On 3/11/2024, the DDS disposed of the open and unsealed Edy's ice cream in the freezer.

On 3/14/2024, the DDS provided an in service on the importance of food being stored in closed or sealed containers.

On 3/17/2024 and ongoing, The DDS will conduct random checks on a weekly basis of the kitchen to verify that food shall be stored in closed or sealed containers.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of food in closed or sealed containers.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (████) - 04/09/2024)

105g - Lint Removal and Duct Cleaning

10. Requirements

- 2600.
- 105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

105g - Lint Removal and Duct Cleaning (continued)

Description of Violation

On 3/11/2024, there was an approximate 1/2-inch accumulation of lint in the lint trap of the dryer in Memory care. There were no clothes in the dryer at the time.

Plan of Correction

Accept (█) - 04/09/2024)

On 3/11/2024, the DES immediately removed lint from the lint trap of the memory care dryer.

On 3/11/2024, the DES inspected all dryers to verify that lint traps and drums were free from lint.

On 3/11/2024 and ongoing, dryers are be inspected daily by the housekeeping/team members to verify lint traps and drum are being properly cleaned from any accumulation of lint.

On 3/13/2024, all housekeeping team members have been re-trained, and education was provided on the importance of cleaning out the lint from the dryer lint traps after each use.

On 3/11/2024 and ongoing, the DES completes random checks on each dryer on a weekly basis to verify compliance with removing lint and duct cleaning will continue a quarterly basis.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of cleaning out the lint from the dryer lint traps after each use.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024)

131f - Fire Extinguisher Inspection

11. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the Reminiscence neighborhood has not been inspected by a fire safety expert since December 2022.

The fire extinguisher in the vehicle has not been inspected by a fire safety expert since October 2022.

Plan of Correction

Accept (█) - 04/09/2024)

On 3/13/24, the DES inspected all other fire extinguisher to ensure they were inspected by a fire safety expert. No additional concerns identified.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of fire extinguisher inspections.

131f Fire Extinguisher Inspection (continued)

On 4/2/24, our fire safety expert inspected the fire extinguisher in the reminiscence neighborhood and on the resident transportation vehicle.

On 4/5/24 and ongoing, the DES will conduct a monthly preventive maintenance check on our fire extinguishers to ensure all have been properly inspected and approved by our fire safety expert.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024

171b5 - First Aid Kit

12. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the Van with license plate HPV 4663 used to transport residents does not include a first aid kit.

Plan of Correction

Accept (█) 04/09/2024

On 3/12/2024, a first aid kit was immediately put in the Van with license plate HPV 4663 used to transport residents.

On 3/12/2024, the ED immediately verified that all other first aid kits were present and available.

On 3/28/2024, The ED held a Team Member Townhall meeting to review the importance of having a first aid kit in our vehicles when providing transportation to residents.

On 4/11/2024 and ongoing, the DES and Activities and Volunteer Coordinator (AVC) will complete random monthly checks on each vehicle that provides transportation to residents to ensure there is a first aide kit.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented (█) - 04/09/2024

181a - Self-adminstration Assist

13. Requirements

2600.

181a Self administration Assist (continued)

181.a. A home shall provide residents with assistance, as needed, with medication prescribed for the resident's self-administration. This assistance includes helping the resident to remember the schedule for taking the medication, storing the medication in a secure place and offering the resident the medication at the prescribed times.

Description of Violation

Resident 2 requires assistance with reminders to self administer medications. The home has failed to provide this assistance, resulting in the resident taking incorrect medications.

Resident 2 was prescribed [redacted], however Resident 2 currently has [redacted] in their room. Resident 2 was prescribed [redacted], however Resident 2 currently has [redacted] in their room.

Resident 2 stated they no longer take [redacted], however these remained on the Medication administration record. The medication is not available for the resident. Resident 2 also stated they no longer take Miralax Powder 17 gm, however these remained on the medication administration record. The medication is not available for the resident.

Plan of Correction

Accept ([redacted] - 04/09/2024)

On 3/12/24, Resident Care Director (RCD) contacted resident 2 CRNP who discontinued [redacted] after reviewing resident 2 chart.

On 3/12/24, CRNP reviewed resident 2 chart and wrote new prescription for [redacted] be taken daily as well as [redacted] to be taken daily.

On 03/12/24, resident 2 was educated on the importance of communication with our wellness staff if there are any changes to medications.

On 03/12/24, the RCD conducted an audit of all residents who administer their medications to ensure the orders were accurate. No additional concerns identified.

On 03/15/24, all wellness nurses have been re trained, and education was provided on the importance of the self administration policy.

On 4/2/24 and ongoing, the wellness nurses or RCD will conduct a monthly wellness visit to ensure residents orders are accurate.

On 4/11/24 and ongoing, This Plan of Correction will be discussed and evaluated quarterly 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.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented ([redacted] - 04/09/2024)