pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SQR OPCO LLC**
LEGAL ENTITY

To operate **ATRIA LAFAYETTE HILL**
NAME OF FACILITY OR AGENCY

Located at **9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **170**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 34**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 9,** **2024** until **July 9,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146650**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing date: July 9, 2024

[redacted]
[redacted]
SQR OPCO, LLC
[redacted]
[redacted]

RE: Atria Lafayette Hill
9303 Ridge Pike
Philadelphia, Pennsylvania 19128
License #: 146650

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on March 25 and 26, 2024 and May 16, 2024, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

July 3, 2024

[redacted]
SQR OPCO LLC
[redacted]

RE: ATRIA LAFAYETTE HILL
9303 RIDGE PIKE
LAFAYETTE HILL, PA, 19444
LICENSE/COC#: 14665

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/25/2024, 03/26/2024 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: *ATRIA LAFAYETTE HILL* **License #**: *14665* **License Expiration**: *06/01/2024*

Address: *9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted]

Legal Entity

Name: *SQR OPCO LLC*

Address: [redacted]

[redacted] of Occupancy

Type: *I-1* **Date**: *04/20/2020* **Issued By**: *Springfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *129* **Waking Staff**: *97*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *03/26/2024*

Inspection Dates and Department Representative

03/25/2024 - On-Site: [redacted]

03/26/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *170* **Residents Served**: *92*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Guidance* **Capacity**: *34* **Residents Served**: *18*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *91*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *37* **Have Physical Disability**: *0*

Inspections / Reviews

03/25/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/19/2024*

04/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/28/2024*

Inspections / Reviews *(continued)*

04/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/16/2024*

07/03/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/15/2024*

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

44g - Telephone Number

1. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 04/26/2024)***

44g Telephone Number
Administrator posted all required phone numbers in a conspicuous place located in the home on 4/1/2024.
Regional Vice President/designee will provide education to the Administrator/Designee on regulation 2600.44g on or before 5/3/2024.
Administrator/Designee will complete weekly audits to ensure compliance with 2600.44g for the next 90 days.
Completion date: 5/3/2023

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 05/29/2024)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home did not run FBI check for staff A, who does not reside in Pennsylvania.

Plan of Correction ***Accept [redacted] - 04/26/2024)***

51 Criminal Background Checks
Administrator submitted fingerprints for Staff A's FBI background check on 3/29/2024. Results were received on 4/5/2024
Community Business Director will complete an audit of all current staff to ensure Criminal History Checks have been completed by 5/15/2024 and issues found will be immediately addressed.
Administrator/Designee will provide additional education to the Community Business Director on regulation 2600.51 by 5/3/2024.
Administrator/Designee and Community Business Director will conduct weekly audits of all new hire files to ensure criminal history checks are completed prior to the employees start date. Audits will begin on 4/29/2024 and will continue for the next 90 days.
Completion Date: 5/15/2024

51 - Criminal Background Check (continued)

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 05/29/2024)

85a - Sanitary Conditions

3. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 03/26/2024 at 11:00 AM, there was an unlabeled urinal (commode) in the shower which was shared by two residents in resident room [redacted].

Repeat Violation: 07/03/2023 et al

Plan of Correction ***Accept [redacted] - 04/26/2024)***

85a Sanitary Conditions
Life Guidance Director labeled commode for resident in apartment [redacted] on 3/28/2024.
Administrator/Designee and Life Guidance Director will complete an audit of all apartments with shared bathrooms to ensure commodes (if any) are labeled. Audit will be completed on or before 5/3/2024.
Regional Care Director will provide education to the Administrator/Designee, Life Guidance Director, and Resident Service Director on 2600.85a and the importance of labeling commodes in shared apartments on or before 5/3/24.
Life Guidance Director/designee will conduct in-service training with direct care staff by 5/15/2024.
For the next 90 days, Administrator/Designee and Life Guidance Director will conduct weekly audits of apartments with shared bathrooms to ensure proper labeling of commodes

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 05/29/2024)

102k - No Common Towel

4. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

Resident room [redacted] have a shared bathroom. There were some used towels including wash clothes in the shared bathroom without any identifying labels.

Plan of Correction ***Accept [redacted] - 04/26/2024)***

102k No Common Towel
Life Guidance Director labeled towels for residents in apartments 004 and 008 with new fabric marker on 3/28/2024.
Life Guidance Director will audit towels in all apartments with shared bathrooms to ensure proper labeling of

102k - No Common Towel (continued)

towels by 5/3/2024 and issues noted will be corrected immediately.
Regional Care Director will provide education to Administrator/Designee and Life Guidance Director on 2600.102k and the importance of labeling towels in apartments with shared bathrooms on or before 5/3/2024. Life Guidance Director/ designee will conduct in-service training with direct care staff by 5/15/2024.
For the next 90 days, Administrator/Designee and Life Guidance Director will conduct weekly audits of apartments with shared bathrooms to ensure proper labeling of towels with fabric marker.

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 05/29/2024)

103g - Storing Food

5. Requirements

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

Description of Violation

A bag of brown sugar on one of the shelves in the service kitchen in the home's Secured Dementia Unit (SDCU) was opened and unsealed. The ice cream tubs in the ice cream freezer in the main kitchen were not covered tightly.

Plan of Correction ***Accept [redacted] - 04/26/2024)***

103g Storing Food
Director of Culinary Services sealed the brown sugar and secured the ice cream lid during the survey. Director of Culinary Services ordered storage canisters on 4/15/2024, which will arrive on or before 4/30/2024, to ensure food proper food storage moving forward.
On or before 4/30/2024, the Director of Culinary Services will conduct an audit to ensure food is secured in closed/secured containers. Any issues noted will be corrected immediately.
Director of Culinary Services will provide training to the kitchen staff on 2600.103g and proper food storage practices including closing and securing products by 4/30/2024.
Administrator/Designee and Director of Culinary Services will audit kitchen weekly starting 4/29/2024 to ensure food is stored in closed or sealed containers for the next 90 days.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 05/29/2024)

103i - Outdated Food

6. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

There was an unlabeled, undated container of what looked like gravy in the walk-in freezer.

Plan of Correction ***Accept [redacted] - 04/26/2024)***

103i Outdated Food
Director of Culinary Services discarded unlabeled container of gravy on 3/26/24.
On or before 4/30/2024, Director of Culinary Services will conduct an audit to ensure all containers are labeled and dated. Any issues noted will be corrected immediately.
Director of Culinary Services will provide training to the kitchen staff on 2600.103i and proper food storage practices including labeling and dating by 4/30/24.
Administrator/Designee and Director of Culinary Services will audit kitchen weekly starting 4/29/2024 to ensure proper food storage practices including labeling and dating for the next 90 days.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 05/29/2024)

132g - Fire Drills Days/Times

7. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills on Saturdays as evidenced by the drills held on 09/23/2023, 08/19/2023, and 07/08/2023.

Plan of Correction ***Accept [redacted] - 04/26/2024)***

132g Fire Drills Days/Times
Administrator/Designee and Maintenance Director met with the representative for Kroker, the Community's third-party fire drill vendor, on 3/29/24 to provide education o Kroker on regulation 2600.132g.
Administrator provided training to Maintenance Director on the importance of following regulation 2600.132g on 3/29/24.
Administrator/Designee and Maintenance Director will meet with the representative for Kroker monthly starting 4/29/2024 to review the date and time of upcoming fire drill and ensure that it meets the requirement of regulation 2600.132g. These meetings will occur monthly for the next 90-days.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 05/29/2024)

141a 1-10 Medical Evaluation Information

8. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation dated [redacted]/2023 did not include (2) Medical Diagnoses (physical/mental) or (8) body positioning/movement.

Repeat Violation: 06/01/2023 et al.

Plan of Correction ***Accept[redacted] 04/23/2024)***

POC-• Resident #1 no longer lives at the community.
• The Resident Services Director (RSD)/ designee will complete an audit of all current resident documented medical evaluations (DMEs) by 5/15/2024, to ensure DME are completed in full. Any issues found during the audit will be addressed immediately.
• Regional Care Director will provide additional education by 5/3/2024 to the Executive Director and Resident Services Director/ designee to ensure compliance with regulation 2600 141a to make sure DMEs are filled out upon admission. Regional Care Director will provide additional training to Executive Director and Resident Services Director/designee on move in process to ensure understanding of requirements for obtaining DME and DME completeness prior to move in by 5/3/2024.
• Executive Director/designee will be meeting with the Resident Services Director/designee weekly starting 4/22/2024 for 90 days to review move-in checklist including all new resident DMEs to ensure compliance with regulation 2600 141a. Resident Services Director will be responsible to ensure continued compliance with regulation.

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented[redacted] - 05/29/2024)

141b1 - Annual Medical Evaluation

9. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident #2's most recent medical evaluation was completed on [redacted]/2023. The resident's previous medical evaluation was completed on [redacted]/2022.

Repeat Violation: 06/01/2023 et al

Plan of Correction ***Accept [redacted] - 04/23/2024)***

• The Resident Service Director (RSD)/ designee will complete an audit of all current resident DMEs by 5/15/2024, to ensure compliance with regulation 2600 141b. Any issues found during the audit will be addressed immediately.
• Regional Care Director will provide additional education by 5/3/2024 to the Executive Director/designee and Resident Services Director/designee to ensure compliance with regulation 2600 141b to ensure DMEs are completed within the required timeframe (annually).
• Executive Director will be meeting with the Resident Services Director/designee weekly starting 4/22/2024 to review new DMEs for next 90 days to ensure compliance with regulation 2600 141b.

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 05/29/2024)

183d - Prescription Current

10. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 03/26/2024, Oxycodone 5 mg (1/2 tab every 4 hours as needed) prescribed for resident #3 was in the home's medication cart; however, the medication was discontinued on 02/12/2024.

Plan of Correction ***Accept ([redacted] 04/23/2024)***

• Resident Services Director and designee removed and destroyed Residents #3 discontinued medication immediately.
• Resident Services Director/designee will audit all carts for any discontinued medications by 4/30/2024. Any issues found were corrected immediately.
• The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling by 5/3/2024. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 5/15/2024.
• The Resident Services Director/designee will audit medication carts weekly starting 4/22/2024 for any expired medication for the next 90 days.

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 05/29/2024)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The current order for resident #4's Lorazepam 0.5 mg is once a day. On 03/26/2024, there were two blister cards of Lorazepam 0.5 mg prescribed for the resident. One blister card read once a day (current order) and the other blister card read twice a day (previous order). There was no direction change sticker on the second blister card.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

• Resident Service Director/Designee placed direction change sticker is on Resident #4 Lorazepam on 3/26/2024.
• Resident Service Director/ designee will audit all medication carts to ensure medication labels match order on MAR by 4/30/2024. Any issues found will be corrected immediately.
• The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling and Medication Cart Audit Process by 5/3/2024. The Resident Services Director/designee will conduct in-service on this training to all medication staff by 5/15/2024.
• The Resident Services Director/designee will audit all carts weekly starting 5/6/2024 or any discrepancies with medication labels to ensure proper labeling for the next 90 days.

Proposed Overall Completion Date: 05/15/2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 05/29/2024)

187a - Medication Record

12. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #4 is prescribed Amlodipine 5 mg, Levetiracetam 750 mg, Lorazepam 0.5 mg, and Mirtazapine 15 mg. However, the resident's medication administration (MAR) record does not indicate the diagnoses for these medications.

Repeat Violation: 06/01/2023 et al

Plan of Correction ***Accept [redacted] - 04/23/2024)***

• Resident Service Director/ designee corrected Resident #4 medication record with physician to indicate the diagnoses/purposes of all medications on 4/19/2024.
• Resident Service Director/designee will complete audit of all medication records to ensure all medication indicate the diagnoses/purposes by 5/15/2024. Any issues found will be corrected immediately.
• The Regional Care Director will provide training by 5/3/2024 to the Executive Director and Resident Services

187a - Medication Record (continued)

Director/designee on the med cart audit process, order verification process to ensure understanding of policies and processes related to all medications orders indicating diagnoses/purposes for use. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 5/15/2024.
• The Resident Services Director/designee will audit order verification forms and med cart audits weekly starting 4/22/2024 to ensure proper documentation in medication record of diagnoses/ purposes for all medication for the next 90 days.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 07/03/2024)

187b - Date/Time of Medication Admin.

13. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #5 is prescribed Donezepil 10 mg at 08:00 PM and Simvastatin 40 mg at 09:00 PM. The resident was not administered these medications on 03/17/2023. However, the resident's March MAR was documented as administered.

Plan of Correction ***Accept[redacted] - 04/23/2024)***

• The Regional Care Director will provide training to the Executive Director and Resident Service Director/Designee on work instruction MED-0002-01 Assistance with/ Supervision of Self-Administration of Medication- Electronic Medication Administration Record (EMAR) by 5/3/2024.
• The Executive Director or Resident Service Director will provide additional training to all medication staff on work instruction MED-0002-01 Assistance with/ Supervision of Self-Administration of Medication- Electronic Medication Administration Record (EMAR) by 5/15/2024.
• The Executive Director and Resident Service Director will audit the Electronic Medication Administration Record weekly starting 4/22/2024 to ensure all medication administration is completed accurately for the next 90 days. completion date 5-15-2024

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] 05/29/2024)

187d - Follow Prescriber's Orders

14. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #5 is prescribed Donezepil 10 mg at 08:00 PM and Simvastatin 40 mg at 09:00 PM. The resident was not administered these medications on 03/17/2023.

Repeat Violation: 06/01/2023 et al.

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept (- 04/23/2024)***

• The Regional Care Director will provide training to the Executive Director and Resident Service Director/Designee on work instruction MED-0002-01 Assistance with/ Supervision of Self-Administration of Medication- Electronic Medication Administration Record (EMAR) by 5/3/2024.
• The Executive Director or Resident Service Director will provide additional training to all medication staff on work instruction MED-0002-01 Assistance with/ Supervision of Self-Administration of Medication- Electronic Medication Administration Record (EMAR) by 5/15/2024.
• The Executive Director and Resident Service Director will audit the Electronic Medication Administration Record weekly starting 4/22/2024 to ensure all medication administration is completed accurately for the next 90 days.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented - 05/29/2024)

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

Resident #1's assessment/support plan (RASP) dated /2023 was not signed by the assessor and the resident.

Resident #6's RASP dated /2024 was not signed by the assessor.

Repeat Violation: 06/01/2023 et al.

Plan of Correction ***Accept (- 04/23/2024)***

• Resident #1 no longer lives at the community. Regional Care Specialist was assessor and will complete signature on assessment/service plan (1/24/2024) for Resident #6 by 4/18/2024.
• Resident Services Director/designee will audit all current residents most recent service plans to ensure compliance with regulation 2600. 227g by 5/15/2024. Any issues found during the audit will be addressed immediately.
• Regional Care Director will provide training to the Executive Director and Resident Service Director/Designee on assessment process to ensure understanding of requirements for obtaining signatures for assessments/service plans per regulation 2600.227g by 5/3/2024.
• Executive Director will meet with Resident Services Director weekly starting 5/1/2024 for the next 90 days to review recent support plans to ensure compliance with regulation 2600 227g.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented 05/29/2024)

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

June 25, 2024

[redacted]
SQR OPCO LLC
[redacted]

RE: ATRIA LAFAYETTE HILL
9303 RIDGE PIKE
LAFAYETTE HILL, PA, 19444
LICENSE/COC#: 14665

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/16/2024 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: *ATRIA LAFAYETTE HILL* **License #**: *14665* **License Expiration**: *06/01/2024*

Address: *9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *SQR OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *125* **Waking Staff**: *94*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *05/16/2024*

Inspection Dates and Department Representative

05/16/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *170* **Residents Served**: *89*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Guidance* **Capacity**: *34* **Residents Served**: *21*

Hospice

Current Residents: *x*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *89*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *36* **Have Physical Disability**: *0*

Inspections / Reviews

05/16/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/08/2024*

06/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/21/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/24/2024*

Inspections / Reviews *(continued)*

06/25/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/21/2024*

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

82c - Locking Poisonous Materials

1. 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 Colgate toothpaste with a manufacture's label indicating "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 in the bathroom of resident room #6. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 06/13/2024)***

On 5/16/24 the Colgate toothpaste was removed and secured immediately. Administrator educated the Life Guidance Director on 5/16/24 on regulation 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). On 5/16/24 Administrator/designee conducted an audit assuring all poisonous materials are secure and inaccessible to residents in resident apartments and common areas in the Life Guidance Neighborhood. Starting On 6/3/24 Life Guidance Director/or designee will train all Life Guidance staff on assuring all poisonous materials are secure and inaccessible to residents in resident apartments and common areas in the Life Guidance Neighborhood. For the next 90 days, Administrator and/or designee will conduct weekly audits of all apartments and common areas in the Life Guidance neighborhood to assure all poisonous materials are secure and inaccessible to residents.
Completion date 6/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 06/25/2024)

187a - Medication Record

2. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 is prescribed Amlodipine 5 mg and resident #2 is prescribed Ketoconazole 2% cream, Levetiracetam 750 mg, and Amlodipine 5 mg. However, the residents' May medication administration records do not indicate the diagnoses for these medications.

Plan of Correction ***Accept [redacted] - 06/13/2024)***

• Resident Service Director/ designee will have medication records for Resident #1 and Resident #2 corrected with physician to indicate the diagnoses/purposes of all medications by 6/12/2024.
• Resident Service Director/designee will complete audit of all medication records to ensure all medication indicate the diagnoses/purposes by 6/30/2024. Any issues found will be corrected immediately.
• The Regional Care Director will provide training by 6/15/2024 to the Executive Director and Resident Services Director/designee on the med cart audit process, order verification process to ensure understanding of policies and

187a - Medication Record (continued)

processes related to all medications orders indicating diagnoses/purposes for use. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 6/30/2024.

• The Resident Services Director/designee will audit order verification forms and med cart audits weekly starting 6/17/2024 to ensure proper documentation in medication record of diagnoses/ purposes for all medication for the next 90 days.

Completion Date: 6/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 06/25/2024)

231c - Preadmission Screening

3. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted]/2024. However, the resident's written cognitive preadmission screening dated 05/02/2024 is missing the determination that the needs of the resident require secured care.

Plan of Correction ***Accept [redacted] - 06/13/2024)***

• Regional Care Director will provide education to the Executive Director/designee and Resident Services Director/designee to ensure compliance with regulation 2600 231.c to make sure Preadmission Screening is completed in full and within the required timeframe according to regulation. Regional Care Director will provide additional training to Executive Director/designee and Resident Service Director/designee on move in process to ensure understanding of requirements for obtaining Preadmission Screening 72 hours prior to move in for all residents requiring secured dementia care unit by 6/15/2024.

• Executive Director/designee will be meeting with the Resident Services Director weekly starting 6/17/2024 to review preadmission screening for all new admissions for next 90 days to ensure compliance with regulation 2600 231.c. Resident Services Director will be responsible to ensure continue compliance with regulation.

• New Preadmission screening was completed for resident #3 on [redacted]/24 to capture need for memory care.

Completion Date: 6/17/2024

Licensee's Proposed Overall Completion Date: *06/17/2024*

Implemented [redacted] - 06/25/2024)