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

May 7, 2024

[redacted], AUTHORIZED PERSON
WELLTOWER OPCO GROUP LLC

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

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/03/2024, 04/04/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SUNRISE OF UPPER ST. CLAIR* **License #**: *44882* **License Expiration**: *12/15/2024*

Address: *500 VILLAGE DRIVE, UPPER ST. CLAIR, PA 15241*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*

Address:

Certificate(s) of Occupancy

Type: *I 2* **Date**: *07/07/2015* **Issued By**: *Township of Upper St. Clair*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *04/04/2024*

Inspection Dates and Department Representative

04/03/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *94* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd Floor* **Capacity**: *36* **Residents Served**: *27*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

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

Have Mobility Need: *40* **Have Physical Disability**: *0*

Inspections / Reviews

04/03/2024 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *04/25/2024*

Inspections / Reviews *(continued)*

04/24/2024 POC Submission

Submitted By: [redacted] **Date Submitted**: *05/03/2024*

Reviewer: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *04/30/2024*

04/29/2024 POC Submission

Submitted By: [redacted] **Date Submitted**: *05/03/2024*

Reviewer: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *05/03/2024*

05/07/2024 Document Submission

Submitted By: [redacted] **Date Submitted**: *05/03/2024*

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

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On numerous dates and times, to include the following, only 1 staff person was present in the home that was trained in first aid and certified in obstructed airway techniques and CPR. On these dates, the home served approximately 68 residents:

- *On 3/31/24 from approximately 12:00am through 7:00 am*
- *On 3/30/24 from approximately 12:00am through 6:45am*
- *On 3/30/24 from approximately 7:00am through 2:45pm*
- *On 3/29/24 from approximately 12:00am through 6:45am*

On 3/31/24 from approximately 7:00am through 3:00pm, there were no staff persons present in the home that were trained in first aid and certified in obstructed airway techniques and CPR. On these day, the home served 68 residents.

Plan of Correction ***Accept ██ - 04/29/2024)***

On 4/04/2024 immediate action was taken by the Executive Director and team coordinators to check and adjust the current 2-week schedule to reflect appropriate staffing needs and staff an individual who is trained and certified in first aid/CPR to be present in the community at all times.
All residents had the potential to be affected by such violation. On 04/04/2024 action was taken by Resident Care Coordinator to schedule a CPR class for any staff members not currently first aid/CPR certified. A first aid and CPR certification class was held on 4/12/2024 allowing more current staff members to be scheduled per shift. Personal Care Director and Resident Care Director will be reviewing the schedule on a weekly basis to ensure a team member who is first aid/ CPR certified is present in the community at all times
On 4/25/2024 an education to be provided by the Executive director to the scheduling team coordinators on CPR Staff to resident ratios in coordination with regulation 2600.63.a. Documentation of education to be kept
Beginning 4/8/2024 Executive Director, Personal Care Director, SDCU Director, or Resident Care director will monitor and adjust CPR trained staff schedules at daily stand up to reflect the needs of the community as it correlates with regulation 2600.63.a. for 6 weeks.
Documentation or actions to be kept. Personal Care Director and Resident Care Director will then be reviewing the schedule on a weekly basis to ensure a team member who is first aid/ CPR certified is present in the community at all times.
The community utilizes an employee CPR certification binder which is monitored monthly by the Business office coordinator. Beginning 4/29/2024 this process will be overseen by the Executive director monthly for 4 months.
Beginning 4/25/2024 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 held on 4/25/2024 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: *07/04/2024*

Implemented ██ - 05/07/2024)

65g - Annual Training Content

2. 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:
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Direct care staff person A, hired on [redacted], did not receive training on the Older Adult Protective Services Act during the 2023 training year.

Plan of Correction ***Accept [redacted] - 04/29/2024)***

On 4/04/2024 immediate action was taken by the Executive Director to ensure staff person A received training on older adult protective services for the current (2024) training year. Staff member completed yearly required training on 2/28/2024. Documentation of education to be kept in accordance with 2600.65.i
Type how will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? And by whom it was completed by.
All residents had the potential to be affected by such violation. On 04/04/2024 action was taken by the Executive Director to review all staff persons within the community to ensure each direct care persons, and substituted care persons is trained on the Older Adult Protective Services Act. On 4/26/2024 all staff members training plans were reviewed to ensure all annual training guidelines are met. Any Team members not currently trained will receive training on 4/25/2024. Documentation to be kept.
On 4/25/2024 an education to be provided by the Executive Director to any current team member out of compliance with The Older Adult Protective Services Act. Executive Director and compliance team will ensure all onboarding team members are trained upon hire. All Team members will receive annual trainings in coordination with regulation 2600.65.g. Documentation to be kept.
Beginning 4/8/2024, Executive Director, Business Office Coordinator, or Community Coordinators will monitor staff training compliances for 5 staff members twice weekly for 4 weeks followed by 5 staff members once weekly for 4 weeks followed by 5 staff members once bi-weekly for 4 weeks. Documentation to be kept.
Team member annual training compliance is monitored and tracked monthly by the community Business office coordinator within our electronic training system and discussed daily at morning meeting. Any staff member in danger of falling out of compliance is placed on a training schedule to complete requirements in coordination with regulation 2600.65.g
Beginning 4/25/2024 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 held on 4/25/2024 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: *07/04/2024*

Implemented [redacted] - 05/07/2024)

132g - Fire Drills Days/Times

3. 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 conducted the last 3 consecutive sleeping hour fire drills during the 3:00am hour on the following dates

132g Fire Drills Days/Times (continued)

and times:

- *2/12/24 at 3:45am*
- *10/18/23 at 3:15am*
- *6/4/23 at 3:05am*

Plan of Correction ***Accept [redacted] - 04/29/2024)***

On 04/04/2024 immediate action was taken by Executive Director to review all fire drills completed in the community for the past 12 months to identify similar patterns.
All residents had the potential to be affected by such violation. On 04/04/2024 action was taken by the executive Director to discuss upcoming fire drills with the Maintenance Coordinator. Times and dates of previous drills as well as upcoming scheduled fire drills were discussed to avoid establishing similar drill patterns
On 4/25/2024 an education to be provided by Executive director to all maintenance team members on fire drill regulations as they correlate to regulation 2600.132.g. Documentation to be kept.
Beginning 4/25/2024 Executive Director and Maintenance Coordinator to review fire drill schedules and plan next drill once monthly to avoid establishing any type of recognized pattern within the community. Documentation to be kept.
Beginning 4/25/2024 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 held on 4/25/2024 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: *07/04/2024*

Implemented [redacted] - 05/07/2024)

141b1 - Annual Medical Evaluation

4. Requirements

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

Description of Violation

Resident #2 was admitted to the home's secured dementia care unit (SDCU) on [redacted]; however, resident #2's most recent medical evaluation, dated [redacted], does not include resident #2's special health/dietary needs or the continued need for resident #2 to be served in the home's SDCU. These sections of resident #2's medical evaluation are blank.

Plan of Correction ***Accept [redacted] - 04/29/2024)***

On 04/04/2024 immediate action was taken by the Resident Care Director to contact resident #2's physician. RCD updated resident #2 DME to reflect special health/dietary needs and the residents need to be served by the community SDCU.
All residents had the potential to be affected by such violation. On 04/04/2024 action was taken by the Resident Care Director reviewed all SDCU resident's most recent DME to reflect accurately the needs of the resident. Documentation to be kept

141b1 Annual Medical Evaluation (continued)

On 4/25/2024 an education to be provided by the Executive Director to the wellness department on resident information specificities and its entirety for DMEs as it correlates to regulation 2600.141.b.1 Documentation to be kept.
Beginning 4/25/2024, Resident Care Director or designated Wellness Nursing team member to review and adjust if needed for 3 resident DME's weekly for 3 weeks followed by 2 residents weekly for 3 weeks followed by 1 resident weekly for 3 weeks. Documentation to be Kept.
Beginning 4/25/2024 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 held on 4/25/2024 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: *07/04/2024*

Implemented [redacted] - 05/07/2024)

162c - Menus Posted

5. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 4/3/24, the menu posted in a conspicuous and public place in the home ended on 3/30/24.

Plan of Correction ***Accept ([redacted] - 04/29/2024)***

On 04/03/2024 immediate action was taken by community Chef to remove and replace dietary menu for upcoming weeks.
On 04/04/2024 action was taken by Executive Director to verify and discuss schedule for posted menus in conspicuous and public places at community stand up with Dining staff.
On 4/25/2024 an education to be provided by Executive Director for all Dietary staff members on menu specifications and timeliness of community menu postings as it correlates to regulation 2600.162.c. Documentation to be kept.
Beginning 4/25/2024, Dinning Services Coordinator, Executive Director, or designated dietary team member to review posted community menus twice weekly for 3 weeks followed by once weekly for 3 weeks followed by once bi weekly for 3 weeks to ensure proper compliance with regulation 2600.162.c. Documentation to be kept.
Beginning 4/25/2024 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 held on 4/25/2024 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: *07/04/2024*

Implemented ([redacted] - 05/07/2024)

224a - Preadmission Screen Form

6. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2 was admitted to the home's SDCU on ; however, resident #2's preadmission screening form, dated indicates a determination that the needs of the resident cannot be met by the services provided by the home.

Plan of Correction ***Accept (- 04/29/2024)***

On 04/04/2024 immediate action was taken by the Resident Care Director to discuss with PMD and correct "Part 3: determination" of the Preadmission screening to reflect resident needs CAN be met by the community.
All residents had the potential to be affected by such violation. On 04/04/2024 action was taken by Resident Care Director and Executive Director to review all resident prescreening for verification of needs met by the community to all residents residing in the community. Documentation to be kept.
On 4/25/2024 an education to be provided by the Executive director to RCD and wellness nursing team on proper usage of preadmission screen form as it correlates to regulation 2600.224.a. Documentation to be kept.
Beginning on 4/25/2024, Executive Director, Resident Care Director, or Wellness nursing team member to review Pre-screener for accuracy of 2 residents weekly weekly for 4 residents weekly for 4 weeks followed by 1 residents weekly for 4 weeks followed by 1 resident bi-weekly for 4 weeks.
The community utilizes a Move-in packet and check list for all admission documentation. Documentation to be kept.
Beginning 4/25/2024 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 held on 4/25/2024 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: *07/04/2024*

Implemented (- 05/07/2024)

227d - Support Plan Medical/Dental

7. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #3's most recent support plan, dated , indicates resident #3 requires the assistance of 2 staff persons to transfer in/out of bed/chair with use of a sit-to-stand lift; however, resident #3 requires the assistance of 2 staff persons to transfer in/out of bed/chair with use of a Hoyer lift for transfers.

Plan of Correction ***Accept - 04/29/2024)***

On 04/04/2024 immediate action was taken by the Resident Care Director to change resident #3's service plan to

227d Support Plan Medical/Dental (continued)

reflect [redacted] need for the use of a Hoyer lift for transfer compared to the use of a sit to stand.
All residents had the potential to be affected by such violation. On 4/05/2024 the Resident Care Director and wellness team reviewed all personal care resident service plans to ensure accuracy. Documentation to be kept.
On 04/25/2024 an education to be provided by The Executive Director to the Resident Care Director and their wellness nursing team members on support plan accuracy and its correlation to regulation 2600.227.d. Documentation of education to be kept.
Beginning 4/25/2024, The Executive Director, Resident Care Director, or designated Wellness Team member will review support plans for 5 residents for 3 weeks followed by 3 resident for 3 weeks followed by 1 resident for 3 weeks. Documentation to be kept.
Beginning 4/25/2024 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 held on 4/25/2024 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. Residents of high concern and higher acuity of care levels will be discussed during weekly IDT/RCA meetings and service plans adjusted accordingly held every Tuesday.

Proposed Overall Completion Date: 07/04/2024

Licensee's Proposed Overall Completion Date: *07/04/2024*

Implemented ([redacted] - 05/07/2024)

231e - No Objection Statement

8. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

There is no documentation present in resident #2's record indicating that resident #2 and resident #2's designated person have not objected to resident #2 admission to the SDCU. Resident #2 was admitted to the home's SDCU on [redacted].

There is no documentation present in resident #4's record indicating that resident #4 and resident #4's designated person have not objected to resident #4 admission to the SDCU. Resident #4 was admitted to the home's SDCU on [redacted].

There is no documentation present in resident #5's record indicating that resident #5 and resident #5's designated person have not objected to resident #5 admission to the SDCU. Resident #5 was admitted to the home's SDCU on [redacted]

There is no documentation present in resident #6's record indicating that resident #6 and resident #6's designated person have not objected to resident #6 admission to the SDCU. Resident #6 was admitted to the home's SDCU on [redacted].

Plan of Correction ***Accept ([redacted] - 04/29/2024)***

On 04/04/2024 immediate action was taken by Director of Sales to obtain signed "No objection statement"

231e No Objection Statement (continued)

documentation from designated person and resident for residents #2, #4, #5, and #6 and placed in resident file.
All residents residing in SDCU had the potential to be affected by such violation. On 04/05/2024 action was taken by the Executive Director and Director of Sales to review all SDCU residents for missing "No objection statement" documentation and corrected if applicable. Documentation of to be kept.
On 04/25/2024 an education to be provide by the Executive Director to the Director of Sales, SDCU Director, and all other admissions coordinators on the purpose of and practical application of "No objection statement" Documentation in correlation with regulation 2600.231.e. Documentation to be Kept.
Type how your will monitor your plan listed above to ensure the deficient practice will not recur, and who will be responsible and date of when this will begin.
Beginning 4/25/2024 The Executive Director, or designated admissions coordinator will review SDCU resident "No objection statement" documentation for 5 residents weekly for 3 weeks followed by 2 residents weekly for 3 weeks followed by 1 resident weekly for 3 weeks. Documentation to be kept. The community utilizes a Move in packet and check list for all admission documentation. It was found that the no objection documentation was missing, but as of 4/04/2024 has since been replaced.
Beginning 4/25/2024 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 held on 4/25/2024 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: *07/04/2024*

Implemented (- 05/07/2024)