

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

September 23, 2024

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

RE: SUNRISE OF GRANITE RUN
247 NORTH MIDDLETOWN ROAD
MEDIA, PA, 19063
LICENSE/COC#: 14490

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/30/2024, 07/31/2024 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 GRANITE RUN* License #: *14490* License Expiration: *01/01/2025*
 Address: *247 NORTH MIDDLETOWN ROAD, MEDIA, PA 19063*
 County: *DELAWARE* Region: *SOUTHEAST*

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: *SZR GRANITE RUN AL OPCO LLC*
 Address: [Redacted]
 Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: *I-2* Date: *09/09/1998* Issued By: *Middletown Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *128* Waking Staff: *96*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *07/31/2024*

Inspection Dates and Department Representative

07/30/2024 - On-Site: [Redacted]
 07/31/2024 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *115* Residents Served: *77*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Reminiscence* Capacity: *36* Residents Served: *30*

Hospice
 Current Residents: *7*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *77*
 Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *51* Have Physical Disability: *0*

Inspections / Reviews

07/30/2024 - Full
 Lead Inspector: [Redacted] Follow-Up Type: *POC Submission* Follow-Up Date: *08/24/2024*

Inspections / Reviews (*continued*)

08/26/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/23/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/29/2024

09/09/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/23/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/07/2024

09/23/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/23/2024

Reviewer: [REDACTED]

Follow-Up Type: Not Required

65f - Training Topics

1. Requirements

2600.

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

- 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff person C and direct care staff person D did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2023.

Plan of Correction

Accept (█) - 09/09/2024)

On 8/6/2024, a Team member file audit was conducted to ensure all the department required trainings are done annually for direct staff person.

On 8/8/2024, Executive Director and Business Office Coordinator will ensure that any staff members missing their annual trainings will complete their 2024 trainings by 9/15/2024.

On 8/8/2024, Executive Director re-trained Care coordinators & Business Office Coordinator to ensure that the department required trainings are done at least annually for direct staff person.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/29/2024

Implemented (█) - 09/23/2024)

82c - Locking Poisonous Materials

2. 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 7/31/24, the laundry room in the SDCU was unlocked. Ecolab Laundry detergent with a manufacture's label indicating "causes serious eye irritation- if irritation occurs, get medical advice/attention," was found unlocked, unattended, and accessible to residents. A tube of Crest 3D Whitening toothpaste with a manufacturer's label indicating "if more than used for brushing is accidentally swallowed, contact poison control center right away" was also found along with a sharps container. Not all the residents of the home, including all residents of the SDCU, have been assessed as capable of recognizing and using poisons safely.

Repeat Violation Date: 7/31/23.

Plan of Correction

Accept (█) - 09/09/2024)

On 7/31/2024, The REM Care Coordinator immediately relocked the door to the laundry room in the secured

82c - Locking Poisonous Materials (continued)

Dementia Unit, removed a tube of toothpaste and discarded it appropriately. [REDACTED] then conducted an audit to check, lock or discard of any poisonous materials in the Secured Dementia Unit. Daily checks are conducted by staff members to ensure that poisonous materials are kept locked and inaccessible to residents in the Secured Dementia Unit.

On 8/8/2024 Care Managers were re-educated on ensuring that poisonous materials are kept locked and inaccessible to residents in the Secured Dementia Unit. Starting 8/28/2024, daily checks to ensure the locking of poisonous materials, will be conducted for 1 week, then weekly checks will be conducted for 4 consecutive weeks followed by monthly checks for 3 consecutive months. These checks will be conducted by a member of the coordinators' team for 3 consecutive months to ensure compliance.

Starting 9/1/2024, monthly checks will be conducted by the care coordinators for 3 consecutive months to ensure compliance.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/29/2024

Implemented [REDACTED] - 09/23/2024)

87 - Lighting

3. 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

On 7/31/24, the emergency lights in stair tower D were flashing.

Plan of Correction

Accept [REDACTED] - 08/26/2024)

On 8/1/2024, Maintenance Coordinator (MC) ordered retrofit replacement lighting kits for the fire escape stairwell lights that were flickering and strobing.

On 8/8/2024, MC installed the retrofit replacement lighting kits replacing the affected lights in the fire escape stairwells. Lights in all fire escape stairwells were checked and are in good working order.

Starting 9/1/2024, MC will conduct monthly lighting checks for all emergency lights in the stair towers. this audit will be conducted for 3 consecutive months.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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.

87 - Lighting (continued)

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 09/23/2024)

100a - Exterior - Free of Hazards

4. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 7/31/24, several raised lips along with several missing bricks were found on the walkway outside of the SDCU, posing a tripping hazard to residents.

Plan of Correction

Accept () - 08/26/2024)

On 8/1/2024, Maintenance Coordinator reached out to local concrete contractors to acquire quotes for the repairs in the Secured Dementia Unit (SDU) garden walkway.

On 8/20/2024, the quote for the repairs were received from the local concrete contractor for the repair of the raised lips in the concrete walkway along with the repair of the missing or loose bricks.

On 8/20/2024, a contractor was selected and the quote for the repair was approved. On 8/21/2024 contractor informed the community that the repair work will commence on Friday August 30th, 2024.

Starting 9/1/2024, monthly checks will be conducted by MC for 3 consecutive months to ensure the concrete walkway in the SDU remains in good repair and free of any tripping hazard. Activities staff will continue to monitor the residents while in the REM garden to ensure their safety while outside in the garden.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/23/2024

Implemented () - 09/23/2024)

103f - Refrigerator/Freezer Temps

5. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 7/31/24 at 11:28am the temperature in the refrigerator in the kitchen was 45 degrees Fahrenheit and at 12:10pm it was 42 degrees Fahrenheit.

Plan of Correction

Accept () - 08/26/2024)

On 7/31/2024, the Secured Dementia Unit/REM refrigerator temperature was immediately adjusted to be at or

103f - Refrigerator/Freezer Temps (continued)

below 40 degrees F. Dining Servicer Coordinator (DSC) successfully locked the temperature control panel to prevent that the temperature is not altered by residents or unapproved personnel.

On 8/1/2024, DSC conducted an audit for all refrigerators in the Secured Dementia Unit/REM to ensure that refrigerators and freezers are kept at appropriate temperature.

On 8/1/2024, DSC conducted a retraining for dining staff in the SDU/REM on the regulation and proper temperatures.

starting 9/1/2024, monthly checks will be conducted by DSC for 3 consecutive months to ensure that refrigerators and freezers are at the correct temperature and had an operable thermostat.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/23/2024

Implemented (█) - 09/23/2024)

107a - Emergency Preparedness

6. Requirements

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person █ the administrator was not familiar with the emergency preparedness plan for the local municipality or where it was located within the home.

Plan of Correction

Accept (█) - 08/26/2024)

On 7/31/2024, a copy of Middletown Township's emergency preparedness plan was located and added to the community's emergency preparedness binder. Another copy is also located in the Executive Director's office.

On 8/1/2024, Executive Director (ED) and Maintenance Coordinator (MC) reviewed Middletown Township's emergency preparedness plan to ensure familiarity.

ED and/or MC will monitor annually to ensure that a copy of Middletown Township is available in the emergency preparedness binder and the Executive Director office and that the plan will be reviewed annually to ensure familiarity.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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.

107a - Emergency Preparedness (continued)

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 09/23/2024

141b1 - Annual Medical Evaluation

8. Requirements

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on (). The resident's previous medical evaluation was completed on ().

Plan of Correction

Accept () - 08/26/2024

On 8/1/2024, Healthcare Manager (HCM) initiated an audit of all active residents' charts to ensure that it contains at a minimum an annual resident medical evaluation. The audit resulted in no further findings.

On or before 9/11/2024, A medical evaluation will be conducted for Resident #1. the date of the most recent medical evaluation is 9/11/2023.

On 8/1/2024, Executive Director initiated a re-training for HCM and Wellness Nurses to ensure that each resident has a medical evaluation conducted at least annually.

Starting 9/1/2024, HCM will continue to monitor PCC system alerts for annual medical evaluations on monthly bases for 3 consecutive months.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/23/2024

Implemented () - 09/23/2024

162c - Menus Posted

9. 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 7/31/24 the home had a week 2 menu posted for week 7/28/24 to 8/3/24. The week 3 menu which would have included the week of 8/4/24 to 8/10 of 8/28/24 was not posted.

Plan of Correction

Accept () - 08/26/2024

On 7/31/2024, Dining Services Coordinator (DSC) immediately printed out and posted the missing menu for the

162c - Menus Posted (continued)

2nd week at the dining Room entrance.

On 8/7/2024, DSC conducted a retraining with dining staff on ensuring that the menus are posted 1 week in advance in a conspicuous place.

Starting 9/1/2024, DSC and Concierge will continue to perform visual checks on daily bases to ensure that a 2-week menu is posted for 3 consecutive months.

Starting 9/1/2024 and quarterly for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/23/2024

Implemented (█) - 09/23/2024

181f - Record of Medication**10. Requirements**

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 7/31/24, resident #2's record did not include a current list of medications. Resident #2 self-administers their medications. Upon inspection of resident #2's medications, it was found that Famotidine 20mg tablet- take one tablet twice per day is not listed on their current medication list. Additionally, resident #2's Benzonite Oral capsule is listed on their medication list as 100mg-1 capsule every 8 hours as needed, but the medication found in the possession of the resident was 200mg- 1 capsule every 8 hours as needed.

Plan of Correction

Accept (█) - 08/26/2024

On 7/31/2024, Resident #2 medication profile was updated to reflect the updated current medication list to ensure that the resident get any needed assistance at the correct prescribed times.

On 8/1/2024, Healthcare Manager (HCM) conducted an audit for all residents who self-administer their own medication to ensure that the residents are receiving appropriate assistance with medication schedule, storage and administration.

On 8/1/2024, Healthcare Manager (HCM) conducted a retraining for wellness staff regarding providing appropriate assistance to residents who self-administer their prescribed medication.

On 8/2/2024, a drop box was installed outside the wellness office and labeled for discharge instructions or after visit summary documentation drop off, for when residents return to the community from the hospital or a doctor's visit after hours.

Starting 9/1/2024, monthly checks for residents who self-administer medication will be conducted by HCM or a licensed Nurse for 3 consecutive months.

181f - Record of Medication (continued)

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/23/2024

Implemented () - 09/23/2024

183e - Storing Medications

11. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 7/31/24, Resident #3's medication card of vitamin D3 was observed to have a punctured blister foil with the medication still present in the spot.

Plan of Correction

Accept () - 08/26/2024

On 7/31/2024, the medication found with punctured foil for resident #3 was destroyed per policy.

Starting 8/1/2024 & ongoing the Med Care Managers and Nurses will check during their narcotic counts to ensure no packaging is damaged or punctured.

On 8/1/2024, Executive Director initiated a re-training for HCM and Wellness Nurses to ensure proper medication storage.

On 8/8/2024 the Resident Care Director spoke with the pharmacy regarding the packaging. Effective 8/15/2024 the pharmacy will be sending out new packaging which has a more secured packaging for medications.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/23/2024

Implemented () - 09/23/2024

187d - Follow Prescriber's Orders

12. Requirements

2600.

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

Description of Violation

On 7/19/24 resident #4 was prescribed probiotic oral capsule 250mg- give one capsule by mouth two times a day for 10 days- start date 7/20/24 0800. The medication was pending delivery from the pharmacy on 7/20/24. Resident #4

187d - Follow Prescriber's Orders (continued)

began receiving the medication on 7/21/24 and only received the medication for 9 days, ending on 7/29/24. The medication should have been given for 10 days.

Plan of Correction**Accept () - 08/26/2024)**

On 7/31/2024, Resident #4 received () last dose of the prescribed medication in question per new prescriber's directions. A new dose time was set due to delays in delivery from the pharmacy.

On 8/2/2024, Healthcare Manager (HCM) conducted an audit for all timed medication orders (such as Antibiotics) with a specific stop date, to ensure accuracy in following the directions of the prescriber.

On 8/8/2024, HCM conducted a training with wellness staff to demonstrate inputting timed medication orders as duration by administration to ensure or contact the prescriber if medication times need to be changed.

HCM and Executive Director will continue to monitor the plan of correction for effectiveness. This will be monitored and reviewed at QAPI meeting for 2 consecutive quarters.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 09/23/2024)**252 - Record Content****13. Requirements**

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.

252 - Record Content (continued)

- 20. The financial records of residents receiving assistance with financial management.
- 21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
- 22. Copies of transfer and discharge summaries from hospitals, if available.
- 23. If the resident dies in the home, a copy of the official death certificate.
- 24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
- 25. A copy of the resident-home contract.
- 26. A termination notice, if any.

Description of Violation

Resident 3's face sheet does not include hair color, eye color or distinguishing marks.

Plan of Correction

Accept ([redacted] - 08/26/2024)

Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

On 7/31/2024 Resident #3 chart was updated to include identifying marks such as (race, height, weight, color of hair, color of eyes, religion affiliation...etc.)

On 8/1/2024, Healthcare Manager (HCM) initiated an audit of all active residents' charts to ensure that each resident's record include all required identifying information per the regulation.

On 8/7/2024, Executive Director initiated a re-training for HCM, care coordinators and Wellness Nurses to ensure that each resident's record include all required identifying information per the regulation.

Starting 9/1/2024, monthly chart checks will be conducted by HCM for 3 consecutive months.

Starting 9/1/2024 for 2 QAPI meetings, the plan of corrections and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting 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: 08/23/2024

Implemented ([redacted] - 09/23/2024)