

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

November 8, 2024

[REDACTED]  
SAGE ATWATER TENANT TRS LLC

[REDACTED]  
Suite 240  
[REDACTED]

RE: ECHO LAKE  
900 NORTH ATWATER DRIVE  
MALVERN, PA, 19355  
LICENSE/COC#: 14713

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/18/2024 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: ECHO LAKE License #: 14713 License Expiration: 04/01/2025  
 Address: 900 NORTH ATWATER DRIVE, MALVERN, PA 19355  
 County: CHESTER Region: SOUTHEAST

**Administrator**

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

**Legal Entity**

Name: SAGE ATWATER TENANT TRS LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: I-1 Date: 09/23/2020 Issued By: Tredyffrin Township

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 113 Waking Staff: 85

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #: [REDACTED]  
 Reason: Complaint, Incident Exit Conference Date: 09/18/2024

**Inspection Dates and Department Representative**

09/18/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: 104 Resident Served: 72

**Special Care Unit**  
 In Home: Yes Area: SDCU Capacity: 38 Resident Served: 23

**Hospice**  
 Current Resident : 9

**Number of Residents Who:**  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 69  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 41 Have Physical Disability: 0

**Inspections / Reviews**

09/18/2024 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/02/2024

Inspections / Reviews *(continued)*

10/24/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/08/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 11/23/2024

11/08/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/08/2024

Reviewer: [REDACTED]

Follow-Up Type: Not Required

23a ADL assistance

1. Requirements

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated 09/07/24, for resident [REDACTED] indicates the resident requires assistance with toileting. On [REDACTED], the resident did not receive this assistance as required.

Plan of Correction

Accept [REDACTED] - 10/24/2024)

2800.23a

POC: All Wellness Associates were reeducated by 10/1/2024 on Resident [REDACTED] Support Plan and the need for an assist x 1 with toileting in addition to the importance of reviewing and adhering to each resident's individual support plan as stated in regulation 2800.23a, by the Health and Wellness Director (HWD).

Beginning 9/19/24, the HWD or designee will observe 5 random Wellness Associate's delivering care to a resident to ensure that it directly aligns with the Support Plan x4 weeks.

HWD is responsible for ongoing compliance.

End date 10/31/24

Licensee's Proposed Overall Completion Date: 10/31/2024

Implemented [REDACTED] - 11/08/2024)

42b Abuse/Neglect

2. Requirements

2800.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED], at approximately 5:40 pm. Staff person A neglected to provide proper care and assistance to Resident [REDACTED]. Resident [REDACTED] current assessment and support plan indicates that resident requires assistance of 1 for transferring, toileting, hygiene, and changing clothing. A resident owned video monitoring camera recorded an interaction between Resident [REDACTED] and Staff member A. In the video, Resident [REDACTED] is observed to be seated in wheelchair, facing the bathroom wall with a grab bar in front of them. Staff Member A was observed to be rough when changing Resident [REDACTED] clothing, yanking or jerking resident's arm in rough manner. Resident [REDACTED] then grabs the bar and slowly begins to stand. Staff Member A quickly removes the wheelchair from behind Resident [REDACTED], who can be seen struggling to continue to stand with their knees bent. Staff Member A removes the wheelchair from the bathroom and is observed to be speaking to the resident and repeatedly pointing to the toilet. At no point did Staff member A provide assistance to resident in pivoting or transferring to toilet. Staff Member A then left the bathroom, while resident was still grasping the bar, still obviously struggling to remain standing. The Staff Member A returns with resident's walker but allows resident to continue to struggle. Resident [REDACTED] is observed to sway, slowly lower themselves a bit, then attempt to pull themselves up again, all while Staff Member A stands next to the resident, talking to the resident and pointing toward the toilet. Resident [REDACTED] then lowers further to the floor and finally releases the bar and falls to the floor in a seated position. Staff person A appears to hold Resident [REDACTED] under their arm while lowering to the floor but did not attempt to help resident remain standing or to turn and sit on the toilet seat. Staff Member A then attempts to have Resident [REDACTED] grasp the safety bar around the toilet but gives up and is then observed to be grab the resident behind their neck, pull

42b Abuse/Neglect (continued)

the resident forward toward the wall by their neck, then scooting resident sideways by their neck and arm. Resident appears to lay back but does not lay fully on the floor. Staff person places an article of clothing on the floor behind residents back, but then leaves the bathroom with the resident in a partially laying position while they are trying to support themselves by grabbing the toilet safety bar.

At this time, Staff Member B heard resident calling for help. Staff Member B found Resident lying on the bathroom floor. Staff Member B and Staff Member A assisted Resident off the floor and placed Resident in their wheelchair. Resident did not sustain any injury during the interaction. The home was made aware of this interaction by the family of Resident who viewed the video and reported their concerns over the treatment resident received.

Plan of Correction

Accept 10/24/2024

2800.42b

POC: Staff Member A was suspended on , immediately following the incident and formally terminated after investigation on .

Echo Lake Wellness Associates were reeducated by the Health & Wellness Director & General Manager on 9/14/24, 9/15/24, 9/16/24 and 9/17/24 on Regulation 2800.42b to ensure that residents are not neglected, intimidated, physically or verbally abused, mistreated, or subjected to corporal punishment in any way.

Beginning 9/19/24 the HWD will speak to 5 random residents weekly x 2 weeks, then bi-weekly x 2 months to ensure residents are not being mistreated or neglected in any way.

HWD is responsible for ongoing compliance.

End date 11/30/24

Licensee's Proposed Overall Completion Date: 11/30/2024

Implemented - 11/08/2024

201 Positive interventions

3. Requirements

2800.

201. Safe Management Techniques - The residence shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

On , at 11 a.m., during the walk through of the home, a banner with an image of a red stop sign and the word stop, placed on Resident door. The door was opened, and Resident was inside the room. Per staff interviews, Resident wanders at night and leaves the room often. The home placed the banner across the open doorway of Resident room to prevent the resident from leaving the room, and to alert staff of when resident has left the room, when staff see that the banner has been taken down. The home is using the banner as a method to confine or restrain resident within their room, instead of utilizing other positive interventions.

Plan of Correction

Accept 10/24/2024

2800.201

POC: Banner was removed immediately on 9/18/24 from Resident door. In addition, the Regional Health &

201 Positive interventions (continued)

Wellness Director reeducated the Health & Wellness Director on 9/18/24 regarding regulation 2800.201 and specifically including the importance of utilizing positive interventions instead of visual banners.

Beginning 9/19/24, HWD will monitor progress notes daily, or within 24 hours, if after hours, x 60 days, to identify any resident or situation that may benefit from utilizing positive interventions to modify or eliminate a behavior that endangers [REDACTED] or others.

HWD is responsible for ongoing compliance.

End Date 11/19/24

Licensee's Proposed Overall Completion Date: 11/19/2024

Implemented ([REDACTED] 11/08/2024)