

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

December 11, 2024

[REDACTED]
WELLTOWER OPCO GROUP LLC

[REDACTED]
ATTN LICENSING
[REDACTED]

RE: SUNRISE OF LAFAYETTE HILL
429 RIDGE PIKE
LAFAYETTE HILL, PA, 19444
LICENSE/COC#: 14324

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/04/2024 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,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SUNRISE OF LAFAYETTE HILL* License #: *14324* License Expiration: *12/15/2024*
 Address: *429 RIDGE PIKE, LAFAYETTE HILL, PA 19444*
 County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *06/18/1998* Issued By: *Whitemarsh Township*

Staffing Hours

Resident Support Staff: Total Daily Staff: *110* Waking Staff: *83*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *11/04/2024*

Inspection Dates and Department Representative

11/04/2024 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *105* Residents Served: *64*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Reminiscence* Capacity: *25* Residents Served: *22*

Hospice
 Current Residents: *16*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *64*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*
 Have Mobility Need: *46* Have Physical Disability: *1*

Inspections / Reviews

11/04/2024 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/24/2024*

11/18/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *12/11/2024*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/23/2024*

Inspections / Reviews *(continued)*

11/19/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/11/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/11/2024

12/11/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/11/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

42c - Treatment of Residents

1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident [REDACTED] was admitted to Reminiscence, the home's secure dementia care unit, on [REDACTED]. The resident's cognitive prescreening indicates the resident has a moderate cognitive deficit and exhibits disorientation and confusion.

On [REDACTED] at approximately 9:45 AM, resident [REDACTED] sat on the lap of resident [REDACTED] in the Reminiscence common area. Staff person A intervened, telling resident [REDACTED] to remove from resident [REDACTED] lap. This led to an argument between resident [REDACTED] and staff person A. Resident [REDACTED] reportedly issued several insults and threats, and staff person A responded in kind, telling resident [REDACTED] they would "kick your [REDACTED]"

Plan of Correction

Accept [REDACTED] - 11/19/2024

After completion of the investigatory process and subsequent interviews with all team members and the resident involved it was found that the allegations were substantiated. Employment for team member Staff Member A was terminated by Colleen Miller, Executive Director on 10/30/24. See attached documentation.

On 11/4/2024 the ED conducted training for all staff persons on a resident's right to be treated with dignity and respect as well as a full review of regulation 2600.42 (A-Y), including but not limited to, being free from any type of abuse and neglect.

The Executive Director or designee will maintain continued compliance through resident observation and ongoing conversations with team members to begin in December 2024 and continue ongoing.

The POC and monitoring process will be discussed during monthly QAPI meetings for 3 months by the Executive Director and/or Resident Care Director beginning on December 3, 2024 through February 2025. If not effective, it will be amended and new POC will be implemented and monitored to ensure incident does not occur again.

QAPI Dates: 12/3/24, 1/7/25, 2/4/25

Licensee's Proposed Overall Completion Date: 11/4/2024

Supporting Documentation Attached.

Licensee's Proposed Overall Completion Date: 11/18/2024

Implemented [REDACTED] - 12/11/2024