pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **WELLTOWER OPCO GROUP LLC**
LEGAL ENTITY

To operate **SUNRISE OF NORTH WALES**
NAME OF FACILITY OR AGENCY

Located at **1419 HORSHAM ROAD, NORTH WALES, PA 19454**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **92** (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 58**

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 **March 11, 2025** until **September 11, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **148061**

ISSUING OFFICER

ACTING 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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 11, 2025

Authorized Person
Welltower OPCO Group LLC

RE: Sunrise of North Wales
1419 Horsham Road
North Wales, PA 19454
License #: 148061

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection August 19 and 20, 2024 and November 14, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 148060 dated November 4, 2024 to November 4, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from March 11, 2025 to September 11, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)

82c	II	70	$5	$350	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *SUNRISE OF NORTH WALES* **License #**: *14806* **License Expiration**: *11/04/2024*

Address: *1419 HORSHAM ROAD, NORTH WALES, PA 19454*

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

Administrator

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

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/21/2012* **Issued By**: *Horsham Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *116* **Waking Staff**: *87*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/18/2024*

Inspection Dates and Department Representative

08/19/2024 - On-Site:

08/20/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *75*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminescence* **Capacity**: *58* **Residents Served**: *29*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *75*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *41* **Have Physical Disability**: *0*

Inspections / Reviews

08/19/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/12/2024*

10/21/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/30/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/31/2024*

01/15/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/30/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 8/1/2024, the home discovered staff person A was accepting tips from residents. The home did not report this incident to the Department.

Plan of Correction ***Accept (█ - 10/21/2024)***

On 8/21/2024 Resident Care Director (RCD) submitted reportable incident to the Department of Human Services and a verbal report was made to the Montgomery County Area on Aging.
On 8/26/2024 the Executive Director (ED) provided an in-service to the RCD and Personal Care Coordinator (PCC) on timely reporting to the Department of Human Services.
On 8/26/2024 the ED audited all reportable incidents from the past 90 days to ensure all have been submitted within 24 hours.
On 8/26/24 and for the next three months the ED to monitor timely incident reporting to the Department of Human services.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Not Implemented (█ - 12/06/2024)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 8/19/2024, at 9:30 am, the medication room was unlocked with a resident listing, daily assignment sheets for residents, and reminder information for residents' care needs.

Plan of Correction ***Accept (█ - 10/21/2024)***

On 8/19/2024 the medication room was immediately locked, and a sign was posted for staff to keep the door locked. Tubi grips were immediately placed in a secure location.
On 8/19/2024 PCC ensured that all medication rooms were locked, and resident information was in a secured location.

17 - Record Confidentiality (continued)

On 8/29/2024 all team members were educated on regulation 17 and protecting residents' personal information.
Starting 8/29/2024 and for the next three months RCD/PCC/RC conduct a minimum of 3 spontaneous audits a week to ensure that med rooms are secured and ensure all resident information is secure.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Not Implemented (- 12/06/2024)

Withdrawn

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b - Abuse *(continued)*

Description of Violation

On numerous occassions Resident 1 pressed their call pendant for assistance with toileting and transferring. On 7/3/2024 the resident pressed the pendant at 3:23 pm and waited 39 minutes 52 seconds; on 7/3/2024 the pendant was pressed at 7:34 pm and waited 45 minutes 25 seconds, on 7/5/2024 the pendant was pressed at 8:13 am and they waited 39 minutes 11 seconds; on 7/8/2024 the pendant was pressed at 8:29 pm and they waited 39 minutes 51 seconds. Resident 1 stated they needed assistance with toileting and they wait for a long time for assistance from the staff. Resident 1 also expressed concern about developing another sore on their buttocks. Resident 1 reported there was an evening where their CPAP machine fell off of their table and the pendant was pressed for assistance, and no one came to help them. The Resident 1 believed they were going to die because they couldn't breatheonce the machine fell and developed a kink in the hose that provides the air thru the mask. Resident 1 reported they banged on the wall until the next-door resident came to the rescue by getting staff assistance. There were no staff available on the floor where the resident resided.

On 8/3/2024, at approximately 12:28 pm, resident 2 left the secure dementia unit by following a visitor to the elevator. Resident 2 took the elevator to the first floor, got off and went to the concierge's desk and explained, "they were new around here and they wanted to go for a walk". The concierge allowed the resident to sign out and leave the building at 12:28 pm. Resident 2 then walked off the property and out to the main road of the home, which has no sidewalks and was located on a heavily trafficked 2 lane road. Staff person B saw the resident, at 12:35pm, walking on the road as they were driving back to the home from break and was able to return Resident 2 to the home. Resident 2 was [redacted] The home was not aware of the resident's absence.

On 8/1/2024 Staff Person B reported to Staff Person C that Staff Person A told them that they were accepting tips from Resident 3, Resident 4, Resident 5 and Resident 6. Staff Person A stated to Staff Person B that they were collecting about $100.00 weekly from these four residents. Resident 4 stated in an interview that they do try to tip staff and that they did tip Staff Person A about $40.00 and that other staff have rejected their tips.

REPEAT VIOLATION: 6/3/2024

Plan of Correction ***Accept ([redacted] - 10/21/2024)***

Situation 1:
On 9/18/2024 all direct care staff were trained on location of ISP in documentation system and trained on resident 1s support plan specifically. Direct care staff were trained to respond to residents call bells timely.
On 9/18/2024 ED, PCC and RC will monitor call bell system to alert the direct care staff to ensure call bells are answered timely.
PCC to review call bell reports daily during morning meeting starting 9/18/2024 for one month, then weekly for one month and then monthly for the following two months.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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.
Situation 2:

42b - Abuse (continued)

On 8/3/2024 resident 2 was immediately identified and walked back to the community. ███ was returned safely to the secured dementia neighborhood.
On 8/3/2024 staff were instructed to do frequent checks on resident 2 as this was ███ first elopement. Resident 2 primary care physician and POA were notified.
On 8/3/2024 ED educated families and staff that while leaving the secured dementia neighborhood to ensure that residents are not tailgating. Families and staff were educated to alert management if they are unsure of someone who is on the elevator with them.
On 8/4/2024 resident 2 was moved to a room further from the elevator where ███ would have to walk through common area space.
On 8/4/2024 the concierge was educated on learning all resident's faces with a binder at the concierge desk.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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.
Situation 3:
On ███ Staff Person B was placed on administrative leave until the investigation was complete.
On ███ Staff Person B was terminated by the facility.
On 8/2/2024 resident 4 stated ███ only gave money to staff person B.
On 8/21/2024 RCD reportable incident to the department of human services and called in a verbal report to OAPS at request of state inspector.
On 8/29/2024 all staff were educated on tipping and gratuity policy and financial exploitation.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Implemented (███ - 12/09/2024)

51 - Criminal Background Check

6. 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

Staff Person D, date of hire ███, did not have a criminal background check thru the Pennsylvania State Police Patch System.

Plan of Correction ***Accept (███ - 10/21/2024)***

On 8/20/2024 Business Office Coordinator (BOC) ran criminal background check for staff person D.
On 8/26/2024 ED educated BOC on ensuring that all team members have a criminal history check and hiring policies according to older adult protective services Act.
On 8/20/2024 BOC completed an audit of team member charts to ensure that a criminal background check was completed for all employees.

51 - Criminal Background Check (continued)

Starting on 8/20/2024 and for the next three months, ED to review all new employee files to ensure that criminal background checks have been completed for all employees upon hire.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Not Implemented (- 12/12/2024)

82c - Locking Poisonous Materials

8. 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 8/19/2024, Secret Deodorant, with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in room Not all the residents of the home, including Resident 8 have been assessed capable of recognizing and using poisons safely.

On 8/19/2024, Denture Cleanser, with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in room Not all the residents of the home, including Resident 8 have been assessed capable of recognizing and using poisons safely.

On 8/19/2024, Lysol Spray Disinfectant, with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in the medication room. Not all the residents of the home, have been assessed capable of recognizing and using poisons safely.

On 8/19/2024, 3 tubes of Medline Remedy Zinc Oxide Paste skin protectant, with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in room Not all the residents of the home, including Resident 9 have been assessed capable of recognizing and using poisons safely.

On 8/19/2024, Gentell A&D ointment skin protectant with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in room Not all the residents of the home, including Resident 9 have been assessed capable of recognizing and using poisons safely.

On 8/19/2024, Spray and Wash Laundry Stain Remover with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in room Not all the residents of the home, including Resident 9 have been assessed capable of recognizing and using poisons safely.

On 8/19/2024, Hand Sanitizer, with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in room Not all the residents of the home, including Resident 10 have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

On 8/19/2024, Nail Polish Remover with a manufacture's label indicating "To contact poison control", was unlocked, unattended, and accessible to residents in the unsecured Activities storage room. Not all the residents of the home, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 1/31/24, et al

Plan of Correction ***Accept (- 10/21/2024)***

On 8/19/2024 all poisonous materials were immediately locked and stored properly.
On 8/19/2024 LCM walked through all resident rooms in secured dementia neighborhood to ensure all poisonous materials were locked and stored properly.
On 8/28/2024 all staff were educated by the ED on properly storing poisonous materials in a secured dementia unit.
Starting 8/29/2024 and for the next three months RCD/PCC/RC conduct a minimum of 3 spontaneous audits a week to ensure that poisonous materials are properly stored.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

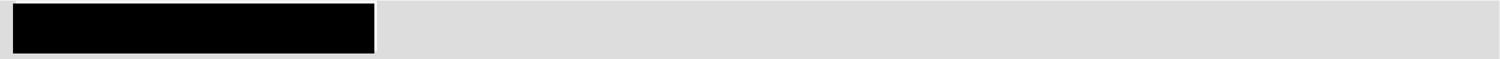
Not Implemented (- 12/12/2024)

Withdrawn

WITHDRAWN 3/10/25

WITHDRAWN AD 3/10/25

.



101i - Access to Bedroom

12. Requirements

2600.
101.i. A resident shall have access to his bedroom at all times.

Description of Violation

On 8/19/2024, resident 7 was denied access to bedroom. The resident does not have a key and the door is kept locked. The resident resides in the secured dementia unit.

On 8/19/2024, resident 8 was denied access to bedroom. The resident does not have a key and the door is kept locked. The resident resides in the secured dementia unit.

Plan of Correction ***Accept (- 10/21/2024)***

On 8/19/2024 resident 7 and resident 8 rooms were unlocked immediately.

101i - Access to Bedroom (continued)

On 8/19/2024 LCM and PCC conducted a walk-through of all resident rooms were unlocked.
On 8/29/2024 all staff were educated on ensuring all residents rooms were unlocked in the secured dementia unit, allowing access to their bedrooms at all times.
Starting 8/29/2024 and for the next three months RCD/PCC/RC conduct a minimum of 3 spontaneous audits a week to ensure that resident shall have access to their bedroom at all times.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Not Implemented (- 12/12/2024)

101j3 - Bed/Linens/Pillows/Blankets

13. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed for resident 9 did not have bedding. It was missing pillows, complete set of linens and blankets.

Plan of Correction ***Accept (- 10/21/2024)***

On 8/19/2024 staff immediately changed sheets and made bed with clean linens.
On 8/19/2024 PCC and LCM conducted a walk through to ensure that all residents have pillows, bed linens and blankets.
On 8/29/2024 direct care staff were educated on ensuring all resident beds have pillows, bed linens, and blanket in clean and good repair.
Starting 8/29/2024 and for the next three months RCD/PCC/RC conduct a minimum of 3 spontaneous audits a week to ensure that resident beds have pillows, bed linens, and blanket in clean and good repair.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Not Implemented (- 12/13/2024)

101j7 - Lighting/Operable Lamp

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

Residents 7, 8, 11 and 12 do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 10/21/2024)***

On 8/19/2024 residents 7, 8, 11, and 12 immediately received access to a light source.
On 8/19/2024 PCC and LCM conducted a walk through to ensure all residents have access to a light source by their bed.
On 8/29/2024 all team members were educated on ensuring that all residents have an operable lamp or lighting source within reach of their bedside.
Starting 8/29/2024 and for the next three months RCD/PCC/RC conduct a minimum of 3 spontaneous audits a week to ensure that residents have an operable lamp or lighting source within reach of their bedside.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Not Implemented (- 12/13/2024)

102h - Toilet Paper

16. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 8/19/2024, there was no toilet paper in the bathroom of room 303.

Plan of Correction ***Accept (- 10/21/2024)***

On 8/19/2024 Maintenance Coordinator (MC) immediately replaced toilet paper in room 303.
On 8/19/2024 MC conducted walk through of all rooms to ensure that all rooms had toilet paper.
On 8/30/2024 MC educated all housekeepers and maintenance assistant on ensuring all rooms have toilet paper.
Starting 8/29/2024 and for the next three months RCD/PCC/RC conduct a minimum of 3 spontaneous audits a week to ensure that residents rooms are provided toilet paper.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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.
REPEAT VIOLATION: 1/31/2024

Licensee's Proposed Overall Completion Date: *10/11/2024*

Not Implemented (- 12/13/2024)

WITHDRAWN **3/10/25**

103f - Refrigerator/Freezer Temps

18. 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

There was no thermometer in the freezer section of the refrigerator located in the memory care unit.

Plan of Correction ***Accept (- 10/21/2024)***

On 8/19/2024 Dining Service Coordinator (DSC) replaced thermometer in small freezer.
On 8/19/2024 DSC conducted an audit to ensure that all refrigerators and freezers had a thermometer.
On 8/29/2024 ED educated DSC on ensuring all refrigerators and freezers have a thermometer.
DSC and/or lead cook to ensure that thermometer is in refrigerator and freezer during weekly inventory check starting 8/29/2024 and for the next three months.
POC and monitoring results are reviewed and evaluated by the ED and coordinators at the Quality Management (Quality Assurance and Performance Improvement/QAPI) meeting for quarter four and quarter one 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: *10/11/2024*

Implemented (- 12/13/2024)

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

Facility Information

Name: *SUNRISE OF NORTH WALES* **License #**: *14806* **License Expiration**: *11/04/2024*

Address: *1419 HORSHAM ROAD, NORTH WALES, PA 19454*

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

Administrator

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

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/21/2012* **Issued By**: *Horsham Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *106* **Waking Staff**: *80*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *11/14/2024*

Inspection Dates and Department Representative

11/14/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminescence* **Capacity**: *58* **Residents Served**: *27*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

11/14/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/22/2024*

Inspections / Reviews *(continued)*

12/26/2024 - POC Submission

Submitted By: [redacted]

Date Submitted: *12/31/2024*

Reviewer: [redacted]

Follow-Up Type: *Document Submission* **Follow-Up Date:** *12/31/2024*

01/15/2025 - Document Submission

Submitted By: [redacted]

Date Submitted: *12/31/2024*

Reviewer: [redacted]

Follow-Up Type: *Enforcement*

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

At 11:07 am, on 11/14/2024, An agent of the Department observed staff person A loudly and harshly yelling at resident 1 "Stay in your chair, stay in your chair or you will get hurt!". Resident 1 was sitting in [redacted] wheelchair facing away from the staff person. Resident 1 cannot hear well unless you are facing and in view of [redacted] This was also witnessed by 3 other staff members including the administrator.

Plan of Correction ***Accept ([redacted] - 12/24/2024)***

11/14/24: ED was with the surveyor during the interaction and immediately approached the CM to coach [redacted] on [redacted] approach and that all resident's shall be treated with dignity and respect.

11/14/24- Surveyor spoke with all care managers and determined there were no other concerns related to treating residents with dignity and respect.

11/18/2024, team members were reeducated in validation and communication techniques utilized to redirect residents with dignity and respect per 2600.42c.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented ([redacted] - 01/15/2025)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania

54a - Direct Care Staff (continued)

nurse aide registry.

Plan of Correction ***Accept (- 12/24/2024)***

11/14/24-BOC instructed team member to provide a copy of H.S. diploma per 2600.54a. School district provided letter of proof of graduation until diploma received.

11/14/24-ED reeducated BOC on 2600.54a to ensure all team member qualifications are met prior to working as a direct care staff person.

11/15/24, ED sent a request for waiver of regulations for 2600.54(a) requesting the one team member's foreign education accepted.

12/1/24 Audit completed for all team members hired within the past 60 days for compliance with education requirements per 2600.54a.

By 12/31/24, all new hire files will include a file checklist for presence of required information/documentation and will not provide direct care until compliance confirmed.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (- 01/15/2025)

82c - Locking Poisonous Materials

3. 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 11/14/2024, at approximately 10:13 am, Remedy zinc oxide paste and moisture barrier cream, both with a manufacturer's label indicating "if ingested call poison control", were unlocked, unattended, and accessible to residents in the memory care kitchenette.

At 10:16 am, 2 tubes of poligrip, one tube of Selan+ zinc oxide and 3 sticks of degree deodorant, all with a manufacturer's label indicating "if ingested call poison control", were unlocked, unattended, and accessible to residents in memory care room 317.

82c - Locking Poisonous Materials (continued)

At 10:36 am, A bottle of CVS health dandruff shampoo with a manufacturer's label indicating "if ingested call poison control", was unlocked, unattended, and accessible to residents in memory care room 324.

Not all the residents of the home, including residents in the memory care unit, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: *1/31/24 et al.*

Plan of Correction ***Accept (- 12/24/2024)***

On 11/14/24, all poisonous materials including zinc paste, toothpaste and shampoo, found during walk through were removed from rooms or locked and inaccessible to residents.

On 11/14/24, the RC, PCC and ED completed a walkthrough of the memory care neighborhood to ensure all poisonous materials were locked and inaccessible to residents.

On 11/18/24, RC reeducated all team members on keeping poisonous materials inaccessible to residents and the use of a formalized room audit to ensure it reflects auditing of all regulatory compliance items related to 2600.82.c.

Beginning 11/30/24, room audits were completed on all rooms daily to ensure regulatory compliance of 2600.82.c. Daily audits will be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed for 30 days. Audits to be reviewed and kept in RC/PCC offices.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (- 01/15/2025)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 11/14/2024, at 10:16 am, room 317 had a strong odor of urine, and the floor in the bathroom was very sticky.

On 11/14/2024, at 10:29 am, in the memory care kitchen there were dead bugs on the top shelf of the refrigerator door and a container of sugar without a lid was also on the top shelf. The wall behind the trash can was covered in dried food debris.

On 11/14/2024, at 10:36 am, in the bathroom of room 324 there were dead bugs and dirt on the shower floor.

85a - Sanitary Conditions (continued)

Dried feces was observed on the shower curtain, and smeared feces on the toilet seat. The bedroom on the right side had a heavily odor of urine.

On 11/14/2024, at 11:07 am, there was a pink tub on a shower chair smeared with feces on the shower chair handle and on the pink tub in the bathroom of room 225.

On 11/14/2024, at 11:19 am, in the bathroom of room 208 there was dried feces smeared on the back of the toilet and on the toilet seat.

Plan of Correction ***Accept (█ - 12/24/2024)***

11/14/25-MC and housekeeping immediately notified of odors, sticky floor, stains, dead bug, showers/toilets and walls that were not clean and corrected the issues in reported rooms.

11/14/24, RC room audits were completed for all resident rooms. common areas and kitchen to assess cleanliness and sanitary conditions. Team members working the shift were educated on what to look for, what to report and what to remedy immediately.

11/15/24, carpet extractions were initiated to remove stains and odors. All team members educated on reporting issues and trained on formalized room and kitchen audits. Audits put in place to ensure identification and communication for timely correction of any issues related to 2600.85.a

On 11/30/24, audits were completed on all rooms, kitchen and common areas to ensure regulatory compliance. Daily audits to be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed 30 days. Audits to be reviewed and kept in RC/PCC offices.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (█ - 01/15/2025)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles *(continued)*

Description of Violation

On 11/14/2024, at 10:29 am, in the memory care kitchen, there was a half full, unattended trash can with a lid with a large hole that did not have a sealing mechanism. The trash can had a foul odor and contained food debris.

Plan of Correction ***Accept (- 12/24/2024)***

11/14/24- Trash was removed immediately and thrown in dumpster. Maintenance replaced trash can with new one with functioning lid.

11/15/24-Reeducation of all team members regarding trash in kitchens and bathrooms being kept in covered trash receptacles that prevent the penetration of insects and rodents per 2600.85.d

On 11/30/24, room audits were completed on all rooms, kitchen and common areas to ensure all trash cans are emptied and have lids as required by 2600.85.d.

On 11/30/24, Daily audits of common area and kitchen trash cans, as well as resident apartment and bathroom trash cans to be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed for 30 days.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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: *12/20/2024*

Not Implemented (- 01/15/2025)

WITHDRAWN **3/10/2025**

101j7 - Lighting/Operable Lamp

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident of room 317 does not have access to a source of light within reach that can be turned on/off at bedside.

Resident of the second bedroom in room 328 does not have access to a source of light within reach that can be turned on/off at bedside.

Plan of Correction ***Accept (- 12/24/2024)***

11/14/2024- RC placed working lamp next to the resident's beds in room 317 and 328 to ensure the resident had access to source of light within reach that could be turned on/off per 2600.101.j.

11/15/24- RC and ED walked apartments to ensure that all other residents have access to source of light within reach that could be turned on/off per 2600.101.j.

11/15/24-team members were reeducated on 2600.101.j requiring each resident to have an operable lamp or other source of lighting that can be turned on at bedside.

11/30/24- daily room audits on all rooms, kitchen and common areas completed to ensure regulatory compliance. Daily audits will be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed for 30 days.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be implemented and monitored to

101j7 - Lighting/Operable Lamp (continued)

ensure the violation does not occur again.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (█ - 01/15/2025)

101o - Walls, Floors, Ceilings

8. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 11/14/2024, at 10:40 am, the carpet in the right bedroom of room 324 had a large stain at the end of the bed and the room smelled strongly of urine.

At 10:42 the wall behind the bed of the second bedroom in room 328 was covered in small reddish splatters of blood or food.

Plan of Correction ***Accept (█ - 12/24/2024)***

11/14/24- Housekeeping/maintenance immediately notified of stains, urine odors and dirty walls in identified rooms and they were immediately cleaned to ensure cleanliness and good repair.

11/15/24- RC, ED performed walk through of all rooms to ensure they were clean and in good repair per 2600.101.o.

11/18/24- Reeducated team members on importance of having all rooms clean and in good repair per 2600.101.o and to report strong odors and stains etc.

11/30/24-Daily Room/common area audits implemented to identify and address carpet stains, odors, and cleanliness concerns in apartments for care managers, housekeeping, or maintenance to address. Daily audits will be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed for 30 days.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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: *12/31/2024*

Not Implemented (█ - 01/15/2025)

103g - Storing Food

9. Requirements

2600.

103g - Storing Food *(continued)*

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

Description of Violation

At 10:26 am in the memory care kitchen the following was observed:
Two balled up, well used, unsealed, undated sticks of butter in the refrigerator.
An unsealed, unlabeled, undated, clear squirt bottle of syrup in the upper cabinet.
A plastic 2-quart unsealed, undated, unlabeled container of sugar with a used cup inside.

At 11:15 am in the second-floor kitchen there was two unsealed and undated containers of applesauce in the refrigerator door.

REPEAT VIOLATION: 1/31/2024

Plan of Correction ***Accept (- 12/24/2024)***

11/14/24- All unlabeled, unsealed, and undated items were immediately removed from the refrigerator and freezer and thrown away.

11/14/24- DSC, care managers and kitchen staff reeducated on 2600.103g regarding the need to label and date properly seal all items sent to the 3rd Floor kitchen for use. DSC completed walk through to ensure all other foods were stored in sealed containers.

11/30/24- Memory care kitchen audits implemented to identify and address unlabeled, undated, and unsealed items within the 3rd floor kitchen. Daily audits will be completed for 30 days, followed by 3x/wk for 30 days.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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: *12/31/2024*

Not Implemented (- 01/15/2025)

WITHDRAWN 3/10/25

.

125a - Combustible Storage

11. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

There was an unlocked unattended oxygen tank stored near a working PTAC unit in memory care room 328.

There was an unlocked unattended oxygen tank stored near a working PTAC unit in memory care room 308. The PTAC unit was on and blowing hot air.

Plan of Correction ***Accept (- 12/26/2024)***

11/14/24- Oxygen tanks were immediately moved away from the PTAC unit/heat source. Two hospice resident's oxygen tanks were moved to a closet in the RC office for permanent, safe storage when not in use.

11/15/24-Team members were educated on 2600.125a to ensure combustible and flammable materials may not be located near heat sources or hot water heaters.

11/30/24- RC initiated room audits on all rooms. No other residents were identified as using oxygen in the memory care neighborhood.

11/30/24- Daily audits of residents on oxygen in memory care will be completed for 30 days, followed by 3x/wk for 30 days.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (- 01/15/2025)

)

. **WITHDRAWN** **3/10/25**

183b - Meds and Syringes Locked

13. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 11/14/2024, at 11:07 am, a tube of Neosporin pain creme was unlocked, unattended, and accessible in room 225.

On 11/14/2024, at 11:19 am, a bottle of Nystatin powder was unlocked, unattended, and accessible in room 208.

Plan of Correction ***Accept (- 12/26/2024)***

11/14/24- Items were immediately removed from resident rooms and turned over to nursing. Residents notified that items were removed and were educated on the requirement of medications to be locked away.

11/15/24- PCC and RCD completed walk of all rooms to ensure prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

183b - Meds and Syringes Locked (continued)

11/18/24-PCC/RCD reeducated team members to ensure compliance with 2600.183.b.

11/22/24- Electronic message sent out to POA's, family members, residents included in email distribution list educating them on Pennsylvania Personal Care Home regulations regarding prescription medications, OTC medications, CAM regulations. The message requested assistance and understanding of the regulations related to residents having, storing, or self-administering medications.

11/30/24- Daily room audits initiated for finding and removing medications from resident apartments of those who are not permitted to have them. Daily audits will be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed for 30 days.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (- 01/15/2025)

183d - Prescription Current

14. 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 11/14/2024, Nystatin topical powder prescribed for resident 2, was in resident 2's bathroom; however, resident 2 is not currently prescribed this medication. Staff stated the resident brought it with them.

Plan of Correction ***Accept (- 12/26/2024)***

11/14/24- Items were immediately removed from resident rooms and turned over to nursing. Residents notified that items were removed and were educated on the requirement of medications to be locked away.

11/15/24- PCC and RCD completed walk of all rooms to ensure prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

11/18/24-PCC/RCD reeducated team members to ensure compliance with 2600.183.b.

11/22/24- Electronic message sent out to POA's, family members, residents included in email distribution list educating them on Pennsylvania Personal Care Home regulations regarding prescription medications, OTC medications, CAM regulations. The message requested assistance and understanding of the regulations related to residents having, storing, or self-administering medications.

183d - Prescription Current (continued)

11/30/24- Daily room audits initiated for finding and removing medications from resident apartments of those who are not permitted to have them. Daily audits will be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed for 30 days.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (█ - 01/15/2025)

184b - Labeling OTC/CAM

15. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 11/14/2024, a package of Neosporin pain creme belonging to resident 3 was in the resident's bedroom and was not labeled with the resident's name.

Plan of Correction ***Accept (█ - 12/26/2024)***

11/14/24- Item immediately removed from resident room and turned over to nursing. Nursing ensured that Neosporin was properly labeled with the resident name.

11/18/24-RCD/PCC educated team members on 2600.184b related to OTC medications and CAM belonging to the resident, must be identified with the resident's name.

11/22/24- Electronic message sent out to POA's, family members, residents included in email distribution list educating them on Pennsylvania Personal Care Home regulations regarding prescription medications, OTC medications, CAM regulations. The message requested assistance and understanding of the regulations related to residents having, storing, or self-administering medications.

11/30/24- Daily room audits initiated for ensuring that all ordered OTC and CAM are labeled with the resident's name. Daily audits will be completed for 30 days, followed by 3x/wk for 30 days. Random audits of 5 apartments per day will then be completed for 30 days. Results to be brought to stand-up daily for review and communication or needed corrections.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

184b - Labeling OTC/CAM (continued)

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (█ - 01/15/2025)

227g -Support Plan Signatures

16. 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 participated in the development of his/her support plan on 2/5/2024. However, the resident did not sign the support plan.

Plan of Correction ***Accept (█ - 12/26/2024)***

11/14/24- PCC spoke with resident and confirmed the resident was unable to sign.

11/15/24-RC/PCC completed an audit to ensure that all Individuals who participate in the development of the support plan shall sign and date the support plan per 2600.227.g.

11/15/24-ED reeducated RC, RCD and PCC regarding 2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

11/16/24- Review to be completed weekly for 60 days to ensure all signatures obtained following support plan review meetings.

POC and monitoring results are to be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 4th quarter 2024 and 1st quarter 2025 to ensure efficacy of the plan. If the plan 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.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Not Implemented (█ - 01/15/2025)