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

January 9, 2025

WELLTOWER OPCO GROUP LLC

ATTN LICENSING

RE: SUNRISE OF NORTH WALES
1419 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14806

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/02/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

## Facility Information

**Name**: *SUNRISE OF 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**: **Total Daily Staff**: *106* **Waking Staff**: *80*

## Inspection Information

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

**Reason**: *Incident* **Exit Conference Date**: *12/02/2024*

## Inspection Dates and Department Representative

*12/02/2024 - 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**: *Reminiscence* **Capacity**: *58* **Residents Served**: *25*

### Hospice

**Current Residents**: *14*

### 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

### 12/02/2024 Partial

**Lead Inspector**: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/29/2024*

### 01/02/2025 - POC Submission

**Submitted By**: **Date Submitted**: *01/07/2025*

**Reviewer**: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/16/2025*

## Inspections / Reviews *(continued)*

### 01/09/2025 Document Submission

**Submitted By:** [redacted]

**Date Submitted:** *01/07/2025*

**Reviewer:** [redacted]

**Follow Up Type:** *Not Required*

## 23a - Activities of Daily Living Assistance

**1. Requirements**

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

**Description of Violation**

*On [redacted] Resident [redacted] was admitted to the memory care unit due to increased confusion and cognitive impairments related to [redacted]. The most recent assessment and support plan, dated [redacted] indicated that Resident [redacted] requires "some supervision" and is at risk of wandering, resident is also able to self-propel in a wheelchair.*
*On [redacted] between approximately 1:20 PM and 2:00 PM, a lapse in supervision occurred, lasting about 30 minutes. At around 1:20 PM, Resident [redacted] and other memory care residents were in the common area after lunch, unsupervised. During this time, there were three direct care staff scheduled in the SDCU. Two care managers, Staff A and Staff B, were in the kitchen washing dishes and setting the tables, while the lead care manager, Staff C, was not present in the unit, on a different floor of the home. Simultaneously, an outside vendor making an equipment delivery on the SDCU, held the elevator open to bring out equipment. Unnoticed by staff, Resident [redacted] wheeled themselves onto the elevator and ended up in the first-floor lobby, which is an unsecured area.*
*Staff D, a lead care manager in personal care, initially saw Resident [redacted] near the elevator on the first floor. Assuming they were under supervision, as they were speaking with another care manager, Staff D continued assisting two other residents. Upon returning approximately 30 minutes later, Staff D found Resident [redacted] still near the elevator on the first floor, unsupervised. Staff members A, B, and C did not realize Resident [redacted] was missing until Staff D escorted them back to the secured memory care unit. The staff involved failed to implement proper safety measures and provide proper supervision to prevent Resident [redacted] elopement from the SDCU during the vendor's delivery and did not promptly recognize Resident [redacted] as a memory care resident or return them to the secured unit upon discovering them out of the SDCU*

**Plan of Correction** ***Accept ([redacted] - 01/02/2025)***

*[redacted]: Once the resident was discovered to be unsupervised, [redacted] was immediately returned to the SDCU by a care manager. Team members were notified of [redacted] absence from the unit and instructed to watch for further attempts to get on the elevator.*
*[redacted]: Team members conducted a sweep of SDCU to ensure all other residents were present on the unit.*
*[redacted]: E.D. verified that signage was present inside/outside the elevators to remind visitors and outside providers to ensure no residents are allowed onto the elevator.*
*[redacted]: Team members educated on the need to check area surrounding elevators when third party vendors arrive for deliveries, to ensure third floor residents are not permitted on the elevator.*
*[redacted]: Medication carts were moved from the activity room, into the TV lounge with window view to the elevators, to increase observation of those coming/going from the elevators.*
*[redacted]: Face sheet binder including pictures of all memory care residents placed at front desk for reference, to ensure no memory care residents are exiting without guidance. In addition, concierge will remind any/all third-party providers to watch their surroundings and prevent third floor residents from entering the elevator.*

*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, quarter one and quarter two 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.*

*23a Activities of Daily Living Assistance (continued)*

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

***Implemented [redacted] - 01/09/2025)***