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

June 25, 2026

[redacted]
MS LOWER MAKEFIELD SH LLC
[redacted]
ATTN LICENSING
[redacted]

RE: SUNRISE SENIOR LIVING OF LOWER MAKEFIELD
631 STONY HILL ROAD
YARDLEY, PA, 19067
LICENSE/COC#: 13809

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/26/2026 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 SENIOR LIVING OF LOWER MAKEFIELD* **License #**: *13809* **License Expiration**: *08/13/2026*

Address: *631 STONY HILL ROAD, YARDLEY, PA 19067*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *MS LOWER MAKEFIELD SH LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/16/2008* **Issued By**: *Lower Makefield Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *85* **Waking Staff**: *64*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/26/2026*

Inspection Dates and Department Representative

03/26/2026 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* **Residents Served**: *53*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *29* **Residents Served**: *24*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *75*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *2*

Have Mobility Need: *32*

Have Physical Disability: *0*

Inspections / Reviews

03/26/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/11/2026*

06/04/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/23/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/14/2026*

Inspections / Reviews *(continued)*

06/18/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/23/2026*

06/25/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

100a Exterior Free of Hazards

1. 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 [redacted] at 10:00 am, the concrete sidewalk was broken where residents walk to sit on the porch outside the home. The concrete was shattered, causing a tripping hazard for the residents.

Plan of Correction ***Accept[redacted] 06/04/2026)***

On 3/26/2026, the MC contacted our service provider for sidewalk repair, in which it is scheduled to be repaired on 5/21/2026 and placed a traffic cone at the areas in need of repair.
On 3/26/2026, Executive Director retrained Maintenance Coordinator on violation 100a as it pertains to the exterior of the building and the building grounds being in good repair and free of hazards.
Effective 3/27/2026 and for 8 weeks, the MC and ED will complete an exterior walk of the grounds to ensure they are in good repair and free of hazards.
Starting 7/8/2025 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: *05/21/2026*

Implemented ([redacted] - 06/18/2026)

125b Combustible Restrictions

2. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On [redacted] at 9:45, two nail polish bins with a flammable caution label, "Keep out of reach of children," were unlocked, unattended, and accessible to resident(s) in the memory care.

Plan of Correction ***Accept[redacted] - 06/04/2026)***

On 3/26/2026 upon finding, the closet door was locked immediately, ensuring those combustible materials were inaccessible to residents.
On 3/26/2026, Executive Director conducted a walk-through of the memory care neighborhood in which no additional combustible materials were accessible to residents.
On 3/27/2026, the Executive Director retrained the Reminiscence Coordinator and the direct care team on regulation 125.b specifically pertaining to all combustible materials not being accessible to residents.
Effective 3/20/2026 and for 8 weeks, the Reminiscence Coordinator will conduct a weekly walk-through of the reminiscence neighborhood to ensure no residents have access to combustible materials.
Starting 7/8/2026 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.

125b Combustible Restrictions *(continued)*

Licensee's Proposed Overall Completion Date: *05/20/2026*

Implemented [redacted] - 06/18/2026)

227g -Support Plan Signatures

3. 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 [redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Repeat Violation [redacted] et.al

Plan of Correction ***Accept [redacted] - 06/04/2026)***

Immediately, on 3/27/2026, the Reminiscence Coordinator reviewed all signature pages to ensure each resident who participated in the development of the support plan signed and dated in which no additional signatures were found missing.
On 3/27/2026, the Executive Director retrained the RC on regulation 227g as it pertains to individuals who participate in the development of the support plan shall sign and date the support plan.
Effective 3/30/2026, and weekly for 8 weeks, the RC and ED will complete support plan signature checks to ensure each resident who participated in the development of the support plan sign and date as per regulation 227g.
Starting 7/8/2026 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: *05/11/2026*

Implemented [redacted] - 06/18/2026)

233c - Key-Locking Devices

4. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU). The home had the wrong code posted on their exit's door.

233c - Key-Locking Devices *(continued)*

Plan of Correction ***Accept [redacted] - 06/04/2026)***

On 3/26/2026, immediately upon finding, the ED posted the correct code at the exit door of the secured dementia care unit. The MC audited all doors of the SDCU and found no additional missing codes as it pertains to regulation 233.c.
On 3/27/2026, the ED retrained the MC on regulation 233.c. as it pertains to key-locking devices, electronic cards systems, or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.
3/30/2026 and weekly for 8 weeks, the MC will audit all doors as it pertains to regulation 233.c to ensure key-locking devices, electronic cards systems, or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device and the correct code is posted.
Starting 7/8/2026 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: *05/11/2026*

Implemented [redacted] 06/18/2026)

234b - Support Plan Needs Elements

5. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated [redacted], for resident [redacted] does not address the residents need for thin liquids as identified in a speech consult dated [redacted]. The home assessed the resident as independent with dining and eating. On [redacted] resident [redacted] was observed coughing while eating their lunch meal quickly. Resident [redacted] was coughing, and staff member A had to pat resident #[redacted] back, when resident [redacted] started vomiting.

Plan of Correction ***Directed [redacted] - 06/04/2026)***

On 3/27/2026 the Executive Director retrained the Resident Care Director, Personal Care Coordinator, and Reminisce Coordinator on regulation 234.b. as it relates to the support plan identifying the resident's physical, medical, social, cognitive, and safety needs.

On 3/27/2026, the Resident Care Director, Personal Care Coordinator, and Reminiscence Coordinator reviewed all service plans to ensure all support plans identify the resident's physical, medical, social, cognitive and safety needs as it relates to regulation 234.b.
Beginning on 3/30/2026 and weekly for the next 8 weeks, the RCD will complete support plan checks for all residents receiving speech services to ensure the support plan identifies the resident's physical, medical, social, cognitive, and safety needs as it pertains to regulation 234.b.
Starting 7/8/2026 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.

234b - Support Plan Needs Elements (continued)

Directed Plan of Correction ([redacted] 6/4/26):

In addition to the steps submitted in the Plan of Correction, the administrator will ensure the additional steps are implemented, starting immediately.

1. Resident [redacted] RASP will be updated to document the resident's dietary needs, as documented on the speech consult.

2. The Resident Care Director will notify the dietary staff of resident [redacted] dietary needs.

3. Documentation of steps 1 and 2 will be maintained for the Departments review.

Proposed Overall Completion Date: 05/11/2026

Directed Completion Date: *05/11/2026*

Implemented ([redacted] 06/25/2026)