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

August 3, 2026

[redacted], REGIONAL DIRECTOR OF OPERATIONS
WELLTOWER OPCO GROUP LLC
[redacted]

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/27/2026, 05/28/2026 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 OF NORTH WALES* **License #**: *14806* **License Expiration**: *07/01/2026*

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

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**: *12/21/2012* **Issued By**: *Horsham Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *85* **Waking Staff**: *64*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/28/2026*

Inspection Dates and Department Representative

05/27/2026 - On-Site: [redacted]

05/28/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *59*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *58* **Residents Served**: *23*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *59*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *26*

Have Physical Disability: *0*

Inspections / Reviews

05/27/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/02/2026*

07/15/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/31/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/31/2026*

Inspections / Reviews *(continued)*

08/03/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2026*

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

42b - Abuse

1. 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.

Description of Violation

On 05/11/26, at approximately 5:35 pm, the alarm at the exit door near room #308 sounded in the memory care unit on the third floor. The first-floor alarm sounded from the same staircase at approximately 5:41 pm. The home was not aware of any residents eloping. At approximately 5:50 pm, the alarm sounded again near room #308 in the memory care unit on the third floor. Resident #1 activated the alarm; staff person A went to the door when it sounded and observed resident #1 at the door. Resident #1 was redirected away from the exit. Staff person B, the memory care coordinator, heard the alarm and initiated a headcount of the residents in the memory care. The home became aware that resident #2 was not in the memory care unit. The home proceeded to complete their elopement protocol. Staff person C went to the staircase that exits room #308 and heard the first-floor exit alarm was sounding. Staff person C exited the building and observed resident #2 siting on a bench that is located on the side of the building near a major crossroad. The resident was redirected back to the facility, and vitals were completed. The home reported that resident #2 did not sustain any injuries.

Repeated Violation - 06/12/2025

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

On 5/11/26, resident #2 was immediately redirected back into the community by care staff. Resident #2 was assessed for injury and none was found. SDCU staff conducted monitoring and observations of the corridor leading to stairwell C. Resident made no further attempt to leave the SDCU unit.

On 5/12/26, the Residence Director started a review and investigation of the situation. Report was made to DHS with findings.

On 5/13/26, the Health Care Director completed an elopement risk assessment on resident #2. Documentation to be maintained.

Starting 5/13/2026, the Residence Director initiated training on 42b and resident elopement prevention and response procedures, including completion of elopement drills. Training was completed by 5/30/2026. Documentation shall be maintained.

Starting 7/1/2026, the Residence Director will complete an elopement drill on all 3 shifts (1 drill each month until all 3 shifts are complete) over the next 3 months. Drill outcomes will be reviewed, and additional training will be provided as needed based on identified opportunities for improvement. Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.42.b. during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)

51 - Criminal Background Check

2. 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 was hired on [redacted]; however, a criminal background check was not completed until [redacted].

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

On 5/29/26, the Residence Director conducted an audit of current associate background check files for employees hired on or after [redacted] The audit confirmed that all required criminal background checks met the requirements of 2600.51. Documentation shall be maintained.

By 6/15/2026, the Residence Director conducted training for current Directors regarding 2600.51, which requires criminal history background checks for all new hires to be completed in accordance with the Older Adults Protective Services Act (OAPSA). Documentation shall be maintained.

Starting 6/1/2026, the Residence Director or designee will review all new staff criminal backgrounds to verify compliance with 2600.51 monthly for 3 months. Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.51 during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)

65a - FS Orientation 1st Day

3. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person D, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe

65a FS Orientation 1st Day (continued)

area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Accept (- 07/15/2026)***

On 4/30/26, the community transitioned management companies from Sunrise Senior Living to Legend Senior Living and initiated audits of associate personnel files to verify compliance with training and documentation requirements outlined in 2600.65a 2600.65g.

On 5/28/26, the Residence Director and Business Office Manager attempted to obtain Staff Person D's new hire orientation documentation from the previous management company; however, the records could not be obtained.

Starting 6/1/26, the Residence Director or designee started retraining current associates including staff person D on the topics required under 2600.65a to ensure compliance with all mandatory training requirements. This training was completed by 7/1/2026.

Starting 6/1/2026, the Residence Director or designee will audit new hire personnel files upon hire to ensure the requirements of 65a are met weekly for 4 weeks.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.65.a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented (- 08/03/2026)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person D completed 40th scheduled work hour on . However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102), reporting of reportable incidents and conditions.

65b Rights/Abuse 40 Hours *(continued)*

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

On 4/30/26, the community transitioned management companies from Sunrise Senior Living to Legend Senior Living and initiated audits of associate personnel files to verify compliance with training and documentation requirements outlined in 2600.65a 2600.65g.

On 5/28/26, the Residence Director and Business Office Manager attempted to obtain Staff Person D's new hire orientation documentation from the previous management company; however, the records could not be obtained.

Starting 6/1/26, the Residence Director or designee started retraining current associates including staff person D on the topics required under 2600.65.b. to ensure compliance with all mandatory training requirements. This training was completed by 7/1/2026.

Starting 6/1/2026, the Residence Director or designee will audit new hire personnel files upon hire and during the onboarding process to verify completion and documentation of mandatory training requirements in accordance with 2600.65.b. The audit will continue weekly for 4 weeks and then bi weekly for 2 months.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.65.b during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person E did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and safe management techniques during training year 2025.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

On 4/30/26, the community transitioned management companies from Sunrise Senior Living to Legend Senior Living and initiated audits of associate personnel files to verify compliance with training and documentation requirements outlined in 2600.65a 2600.65g.

65f - Training Topics (continued)

On 5/28/26, the Residence Director and Business Office Manager attempted to obtain Staff Person E's training record on 2600.65.f from the previous management company; however, the records could not be obtained.

Starting 6/1/26, the Residence Director or designee started retraining current associates including staff person E on the annual topics required under 2600.65.f. to ensure compliance with all mandatory training requirements. This training will be completed by 7/1/2026.

By 6/15/2026, the Residence Director or designee will audit current personnel files on 2600.65f. Any staff found to be out of compliance will have training by 7/1/2026. Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.65.f. during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)

65g - Annual Training Content

6. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person E did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year January 2025 to December 2025.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

On 4/30/26, The community transitioned management companies from Sunrise Senior Living to Legend Senior Living and initiated audits of associate personnel files to verify compliance with training and documentation requirements outlined in §§2600.65a–2600.65g.

5/28/26: The Residence Director and Business Office Manager attempted to obtain staff person's E new-hire training documentation and annual trainings from the previous management company; however, the records could not be obtained.

Starting 6/1/26, the Residence Director or designee started retraining current associates including staff person E on the annual topics required under 2600.65.g. to ensure compliance with all mandatory training requirements. This

65g Annual Training Content (continued)

training will be completed by 7/1/2026.

By 6/15/2026, the Residence Director or designee will audit current personnel files on 2600.65.g. Any staff found to be out of compliance will have training by 7/1/2026. Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.65.g. during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 05/27/26, at approximately 10:00 am, the hot water temperature in the bathroom of room #304 measured 123.8 degrees Fahrenheit. On 05/28/26, at approximately 10:00 am, the hot water measured 123 degrees Fahrenheit.

On 05/27/26, at approximately 10:30 am, the hot water temperature in the bathroom of room #111 measured 122.7 degrees Fahrenheit. On 05/28/26, at approximately 10:30 am, the hot water measured 122.8 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

On 5/28/26, the Maintenance Director contacted Mallard Plumbing immediately to assess, diagnose, and repair any equipment contributing to water temperatures exceeding the allowable threshold stated in 2600.89b, within the community. Documentation maintained.

On 6/1/2026, the Residence Director trained the Maintenance Director on 89b. Documentation shall be maintained.

On 6/9/26, the Maintenance Director confirmed that repairs and replacement of the equipment identified as contributing to elevated water temperatures were completed, restoring water temperatures to compliant levels. Documentation maintained.

Starting 6/15/2026, the Maintenance Director or designee will conduct 5 resident room water temps weekly for 4 weeks to ensure ongoing compliance with 2600.89(b). Results will be documented and reviewed to verify that hot water temperatures do not exceed 120 degrees Fahrenheit. Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.89.b. during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

89b Hot Water Temperature *(continued)*

Implemented ([redacted] - 08/03/2026)

101j3 Bed/Linens/Pillows/Blankets

8. 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

Resident #3's bed did not have bed linens on it.

Resident #4's bed did not have bed linens on it.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

We respectfully request this violation be withdrawn. The regulation requires that residents have pillows, bed linens, and blankets that are clean and in good repair. At the time of the inspection, the linens in the identified rooms had been removed for laundering and airing due to resident incontinence. Clean linens were available and ready for use. The linens were temporarily not on the beds while staff addressed mattress cleaning concerns in accordance with 2600.101(j)(1), which requires mattresses to be clean and in good repair.

Immediately on 5/27/26, care staff cleaned resident #3's and Resident #4's beds and clean linens were replaced, and the beds were made to ensure the residents' comfort and well-being.

By 6/15/26, the Residence Director trained current direct care associates regarding 2600.101(j)(3), which requires that residents have pillows, bed linens, and blankets that are clean and in good repair.

Starting 5/27/2026, care staff will immediately replace bed linens following mattress cleaning or the laundering of linens to ensure beds remain properly made and available for resident use.

Starting 6/1/2026, the Residence Director or designee will audits three resident rooms daily for 2 weeks and then weekly for 2 weeks to monitor compliance with this requirement. Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.101.j.3. during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)

132c Fire Drill Records

9. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

132c - Fire Drill Records *(continued)*

Description of Violation

The fire drill record for the drills conducted on 04/28/2026, 01/12/26, 12/13/25, 11/13/25, and 10/28/25 do not include am/pm.

Plan of Correction ***Accept (- 07/15/2026)***

On 5/29/26, the Residence Director reviewed all fire drill records and added the correct designated AM or PM times. Documentation maintained.

On 6/1/26, the Residence Director provided training to the Maintenance Director and community managers regarding 2600.132.c. to ensure accurate completion and maintenance of fire drill records. Documentation shall be maintained.

Starting 6/1/2026, the Residence Director will review the fire drill record monthly for accuracy and completion through the end of the year. Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.132.c during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented (- 08/03/2026)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #5 is prescribed Acetaminophen 500 mg; take two tablets by mouth every 8 hours as needed for pain. On 05/27/26 this medication(s) was not available in the home.

Plan of Correction ***Accept (- 07/15/2026)***

On 5/27/26, the Health Care Director immediately contacted the pharmacy regarding the missing medication(s) and the need for prompt delivery to ensure uninterrupted medication administration. Medication was delivered that day.

On 5/27/26, the Health Care Director provided immediate education to current medication tech's regarding the requirement to promptly communicate any missing medications, including delays related to pharmacy fulfillment or family-provided medications, to ensure timely follow-up and continuity of care. Documentation shall be maintained.

By 6/15/2026, the Health Care Director will train current medication tech's on the requirements of 2600.185(a), including procedures for the safe storage, access, security, distribution, and use of medications and medical equipment by trained staff persons. Documentation shall be maintained.

Starting 6/29/2026, the Health Care Director or designee will conduct audits of five residents' medication supplies weekly for 2 weeks and then monthly for 2 months to verify that all prescribed medications are available for

185a Implement Storage Procedures (continued)

administration in accordance with physician orders and to ensure compliance with 2600.185(a). Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.185.a during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)

187d - Follow Prescriber's Orders

11. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #5 is prescribed Metoprolol SUCC ER 50 mg Tab; take one tablet by mouth daily hold for SBP less than 110 or pulse less than 60. On 05/23/26, at 8:00 am, resident #5's pulse was 58 and was administered Metoprolol SUCC ER 50 mg Tab.

Resident #6 is prescribed Insulin Lispro INJ (100 units/ml); inject as per sliding scale at 8:00 am, 12:00 pm, and 5:00 pm: 201 250 2 units, 251 300 4 units, 301 350 6 units, 351 400 8 units, and 401 450 10 units. On 05/26/26, at 2:38 pm, resident #6's blood glucose was 340, requiring 6 units of Lispro INJ. However, resident #6 was administered 4 units of Insulin Lispro INJ on 05/26/26 at 12:38 pm.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

On 5/28/26, the Health Care Director notified the physicians and responsible parties/families of the identified medication administration errors involving failure to follow prescribed physician parameters.

Starting 5/29/26, the Health Care Director or designee will train current medication tech's regarding compliance with 2600.187(d), emphasizing the requirement to administer medications in accordance with the prescriber's orders and directions. Training was completed by 6/15/2026. Documentation shall be maintained.

Starting 6/29/2026, the HCD will conduct audits of 5 resident medication records weekly for 4 weeks and then bi weekly for 2 months to verify compliance with physician orders and the requirements of 2600.187(d). Documentation shall be maintained.

On 07/21/2026, the Residence Director or designee, will review the above findings for 2600.187.d. during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/03/2026)