

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

August 25, 2025

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

RE: SUNRISE OF NEWTOWN SQUARE
333 SOUTH NEWTOWN STREET
ROAD
NEWTOWN SQUARE, PA, 19073
LICENSE/COC#: 14326

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/17/2025, 06/18/2025 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 NEWTOWN SQUARE* License #: *14326* License Expiration: *12/15/2025*
 Address: *333 SOUTH NEWTOWN STREET ROAD, NEWTOWN SQUARE, PA 19073*
 County: *DELAWARE* 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: *C-2 LP* Date: *11/07/2002* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *89* Waking Staff: *67*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *06/18/2025*

Inspection Dates and Department Representative

06/17/2025 - On-Site: [REDACTED]
 06/18/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* Residents Served: *66*

Secured Dementia Care Unit

In Home: *Yes* Area: *Reminiscence* Capacity: *26* Residents Served: *19*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *66*
 Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *23* Have Physical Disability: *0*

Inspections / Reviews

06/17/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/17/2025*

07/23/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *08/22/2025*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/24/2025*

Inspections / Reviews (*continued*)

08/25/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/22/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

41e - Signed Statement

1. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident’s designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident’s record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Accept ([redacted]) - 07/23/2025

Plan of correction:

- On 6/19/25 the Regional Director of Operations, RDO, educated the Executive Director, ED, and Director of Sales, DOS on the requirements stated within 2600.41.e Exhibit A in-service form
 - On 6/19/25 the ED had resident #1 sign statement to ensure we were in compliance with 2600.41.e
 - o Exhibit A-2 signed form
 - On 6/20 ED audited all resident files to ensure resident rights statement signed
 - o Exhibit A-3 audit tool
 - Beginning 6/23/25, for 60 days the ED or designated person will audit any new resident file for signatures
 - o Exhibit A-4 audit tool
- OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented ([redacted]) - 08/25/2025

65g - Annual Training Content

2. 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 persons A and B did not receive in-person fire safety training during training year 2024.

Plan of Correction

Accept ([redacted]) - 07/23/2025

Plan of Correction:

65g - Annual Training Content (continued)

On 6/19/25 the ED educated Coordinator team on the requirements stated within 2600.65.g Exhibit A-1 in-service form

- On 6/20/25 the RCD completed training with staff member A,B,C on 2600.65.g Exhibit B-1 in-service form
- On 6/23/25 BOC audited all employee files to ensure training requirements were completed Exhibit B-2 audit tool
- Beginning 6/30/25, for 60 days the ED will monitor compliance to ensure that the BOC completed 2600.65.g trainings for new hires during orientation Exhibit B-3 audit tool

OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented () - 08/25/2025

95 - Furniture and Equipment

3. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 6/18/25, the drain cover to the bathtub in room 321 was not attached to the bathtub.

Plan of Correction

Accept () - 07/23/2025

Plan of Correction:

On 6/18/25 during the survey walk thru the Maintenance Coordinator(MC) immediately fixed the drain. Exhibit C-1 picture of drain

On 6/19/25 the ED educated all management team on the requirements stated within 2600.95

- Exhibit A-1 in-service form
- On 6/20/25 the MC or Houskeeper checked all room drains Exhibit C-2 audit tool
- Beginning 6/30/25, weekly for 60 days the MC or Housekeeper will complete room checks to ensure no issues with drains Exhibit C-3 audit tool

OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented () - 08/25/2025

103d - Storing Food Off Floor

4. Requirements

103d - Storing Food Off Floor (continued)

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 6/18/25, the home's emergency water supply was stored on the floor in room 309.

Plan of Correction

Accept () - 07/23/2025)

Plan of Correction:

On 6/18/25 during the survey walk thru the Maintenance Coordinator(MC) immediately put the water on crates off floor. Exhibit D-1 picture of water

On 6/19/25 the ED educated all Coordinators on the requirements stated within 2600.103.d

- Exhibit A-1 in-service form
 - Beginning 6/30/25, weekly for 60 days the Dining Service Coordinator(DSC) will complete storage checks to ensure no food or supplies are on the floor
 - o Exhibit D-2 audit tool
- OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented () - 08/25/2025)

103f - Refrigerator/Freezer Temps

5. 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

On 6/17/25, there was no thermometer in the freezer in the Reminiscence kitchenette.

Plan of Correction

Accept () - 07/23/2025)

Plan of correction:

On 6/17/25 during the survey walk thru the DSC immediately put a thermometer in the freezer Exhibit E-1 picture of thermometer

On 6/19/25 the ED educated Coordinators on the requirements stated within 2600.103.d Exhibit A-1 in-service form

- On 6/30/25 DSC audited all freezers and fridges to ensure compliance with 103.f
 - o Exhibit E-2 audit tool
- Beginning 6/30/25, daily for 60 days the DSC or Care Staff will check the thermometer in place and reading correct temperature
 - o Exhibit E-3 audit tool

OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented () - 08/25/2025)

107c - Food/Water 3 Day Supply

6. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 6/18/25, the home served 66 residents, requiring 198 gallons of emergency drinking water; however, the home had only 72 gallons of emergency drinking water on site. The home does not have a contract with a local bottled water supplier that includes emergency delivery within 24 hours.

Plan of Correction

Accept ([redacted] - 07/23/2025)

Plan of Correction:

On 6/19/25 the ED educated Coordinators on the requirements stated within 2600.95

- Exhibit A-1 in-service form
- DSC ordered emergency water supply for 3 days
 - o Exhibit F-1 receipt of water order
 - o Exhibit F-2 delivery service contract for emergency water
- Beginning 6/30/25, weekly for 60 days the DSC will check compliance of enough water for 3-day emergency supply is avail onsite
 - o Exhibit F-3 audit tool

OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented ([redacted] - 08/25/2025)

107d - Procedure Emergency Management Agency Submission

7. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were last submitted to the local emergency management agency on 5/19/25. The previous emergency management submission was completed on 1/23/24.

Plan of Correction

Accept ([redacted] - 07/23/2025)

Plan of correction:

On 6/19/25 the RDO educated the ED on the requirements stated within 2600.107.d Exhibit A in-service form ED will monitor annually to ensure emergency procedures reviewed, updated, and submitted to local emergency management agency.

OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 07/18/2025

107d - Procedure Emergency Management Agency Submission (continued)

Implemented () - 08/25/2025

132c - Fire Drill Records

8. 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.

Description of Violation

The fire drill record for the drill conducted on 7/24/24 does not include what time the drill was completed (am/pm).

Plan of Correction

Accept () - 07/23/2025

Plan of Correction:

On 6/19/25 the ED educated Coordinators on the requirements stated within 2600.132.c Exhibit A-1 in-service form
On 6/19/25 the ED confirmed with MC the exact time of drill was conducted in the PM. During DHS survey no additional issues were found.

- Beginning 7/1/25, monthly for 3 months the MC will check fire drill logs for compliance of time
- o Exhibit G-1 audit tool

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented () - 08/25/2025

183e - Storing Medications

9. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 6/18/25, the following medication cards were observed to have a punctured blister foil with the medication still present in the spot and tape covering the opening:

- Resident #2's Ondansetron HCL 4mg tab

Resident #3 is prescribed Metoclopram 10mg as needed for hiccups. The medication should have been discarded after 6/7/25 per instructions. The medication was still present in medication cart on 6/18/25 at 10am.

Plan of Correction

Accept () - 07/23/2025

Plan of correction:

On 6/18/25 the RCD immediately discarded resident #2 Ondansetron pill from bubble pack, resident #3 Metoclopram was immediately discarded

On 6/19/25 the ED educated all Coordinators on the requirements stated within 2600.183.e Exhibit A-1 in-service form

- On 6/25/25 the RCD educated wellness nurses and medtechs on the requirements stated within 2600.183.e

183e - Storing Medications (continued)

- o Exhibit H-1 in-service form
 - On 6/29/25 RCD did audit on all medcarts to ensure all bubble packs were sealed correctly and no expired meds.
 - o Exhibit H-2 audit tool
 - Beginning 6/30/25 weekly for 8 weeks, the RCD or Wellness staff will audit med carts to ensure no expired medications are on carts nor taped backs of blister cards.
 - o Exhibit H-3 audit tool
- OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 08/23/2025

Implemented (████) - 08/25/2025

184c - Sample Prescription Meds.

10. Requirements

2600.

184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

A sample of Synthroid 25mcg belonging to resident #4 was found in the medication cart. The label for this sample did not include it's instructions for use.

Plan of Correction

Accept (████) - 07/23/2025

Plan of Correction:

- On 6/18/25 the RCD immediately corrected the sample medication with complete instructions. Exhibit I-1 picture of medication with instructions
 - On 6/19/25 the ED educated Coordinators on the requirements stated within 2600.184.c Exhibit A-1 in-service form
 - On 6/25/25 the RCD educated wellness nurses and medtechs on the requirements stated within 2600.184.c
 - o Exhibit H-1 in-service form
 - On 6/29/25 RCD did audit on all medcarts to ensure all sample medications had proper labels
 - o Exhibit H-2 audit tool
 - Beginning 6/30/25 weekly for 8 weeks, the RCD or designated staff will audit med carts to ensure all medications have proper instructions.
 - o Exhibit H-3
- OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 08/23/2025

Implemented (████) - 08/25/2025

191 - Resident Right to Refuse

11. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted [REDACTED], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept ([REDACTED] - 07/23/2025)

Plan of correction:

On 6/19/25 the RCD immediately educated resident #1 their right to refuse medication Exhibit A-2 resident signed resident rights form

On 6/19/25 the ED educated all Coordinators on the requirements stated within 2600.191 Exhibit A-1 in-service form

• On 6/25/25 the RCD educated wellness nurses and medtechs on the requirements stated within 2600.191 Exhibit H-1 in-service form

• On 6/19/25 the ED had resident #1 sign statement
o Exhibit A-2 signed form

• On 6/20 ED audited all resident files to ensure resident rights statement signed
o Exhibit A-3 audit tool

• Beginning 6/23/25, for 60 days the ED or RCD will audit any new resident file for signatures re: their right to refuse medication
o Exhibit A-4 audit tool

OC and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement /QAPI meeting for 3rd and 4th quarters of 2025 to ensure efficacy of the plan. If the plan is no longer effective, it will be amended and a new POC will be initiated.

Licensee's Proposed Overall Completion Date: 08/23/2025

Implemented ([REDACTED] - 08/25/2025)

236 - Staff Training

12. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person C, who works in the Secure Dementia Care Unit (SDCU) had only 1 hour of training in dementia care during the 2024 training year.

Plan of Correction

Accept ([REDACTED] - 07/23/2025)

Plan of Correction:

On 6/19/25 the ED educated all Coordinators on the requirements stated within 2600.236 Exhibit A-1 in-service form

• On 6/23/25 the BOC and designated staff audited all direct care worker staff files for 2024 training year dementia training
o Exhibit B-2 audit tool

236 - Staff Training (continued)

- On 6/25/25 thru 7/16/25 RC provided 6hrs of training to staff person C and other staff who were out of compliance with Dementia training
 - o Exhibit B-4 in-service form
- Beginning 6/30/25, ED for 2 months will monitor to ensure compliance of 2600.235 he RC will review new hires have completed 6hrs of dementia training
 - o Exhibit B-3 audit tool

Licensee's Proposed Overall Completion Date: 07/31/2025

Implemented ([REDACTED] - 08/25/2025)