



November 4, 2019

Mr. Donald Feltman  
President / CEO  
Artis Senior Living of Bethel Park, LLC  
680 American Avenue, Suite 101  
King of Prussia, Pennsylvania 19406

RE: Artis Senior Living of South Hills  
1001 Higbee Drive  
Bethel Park, Pennsylvania 15102  
License #: 449160

Dear Mr. Feltman:

As a result of the Department's Bureau of Human Services Licensing annual inspection on August 22, 2019, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa. Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to [https://www.surveymonkey.com/r/BHSL\\_Inspection](https://www.surveymonkey.com/r/BHSL_Inspection).

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written over a white background.

Kevin Hancock  
Deputy Secretary  
Office of Long Term Living

Enclosure  
Violation Report

## Violation Report

### Facility Information

Name: *ARTIS SENIOR LIVING OF SOUTH HILLS* License Number: *44916*  
Address: *1001 HIGBEE DRIVE,, BETHEL PARK, PA 15102*  
County: *ALLEGHENY* Region: *WESTERN*

### Administrator

Name: *Claudia McIntyre* Phone: *4125958917* Email: *cmcintyre@artismgmt.com*

### Legal Entity

Name: *ARTIS SENIOR LIVING OF BETHEL PARK LLC*  
Address: *680 AMERICAN AVENUE, SUITE 101, KING OF PRUSSIA, PA, 19406*

### Certificate(s) of Occupancy

Type: *1-2* Date: *04/19/2018* Issued By: *Municipality of Bethel Park*

### Staffing Hours

Resident Support Staff: Total Daily Staff: *96* Waking Staff: *72*

### Inspection

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

### Inspection Dates and Department Representative

*08/22/2019 - On-Site: Vicki Siegert, Scott Klein, Lauren Spagna, Jon Kimberland*

### Resident Demographic Data as of Inspection Dates

#### General Information

License Capacity: *72* Residents Served: *48*

#### Secured Dementia Care Unit

In Home: *Yes* Area: *Entire license* Capacity: *72* Residents Served: *48*

#### Hospice

Current Residents: *0*

#### Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *48*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *48* Have Physical Disability: *0*

25b - Contract Signatures

Regulations

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1's contract, completed on 5/18/18, was not signed by the resident nor was there indication that the resident was unable to sign.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #1 is unable to sign the resident agreement due to her diagnosis and her agreement was corrected to include such on 8-22-19 (see attached). Education was provided to the Director of Marketing and the Director of Community Relations to ensure agreement is completed accurately where resident either signs or there is an indication of the resident being unable to sign. Quarterly audits will be conducted by designee to ensure compliance and results will be reported in QA meeting (see attached audit and education forms)

Legal Entity Representative

Signature: *Claudia McIntyre* Printed Name and Title: *Claudia McIntyre, ED* Date: *9-27-19*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 10/2/19  
(Date)

Plan of correction implementation status as of 10/2/19  
(Date)

The above plan of correction was approved by *SM*  
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

42s - Privacy

Regulations

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 8/22/19 at approximately 10:00 a.m., there were no signs posted that indicate that the exit from the secured area to the home's main lobby is video recorded.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

This sign was posted by the exit from the secured area to the community main lobby immediately during DHS inspection 8-22-19

See Attached A1

Legal Entity Representative

*Claudia McIntyre*  
Signature

*Claudia McIntyre, ED*  
Printed Name and Title

*9-27-19*  
Date

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123b - Emergency Procedures Posted

Regulations

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

At 10:08 a.m., the home's and the local municipality's emergency procedures were not posted in a public and conspicuous place. The plans were located in the office behind the reception desk.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The Emergency Preparedness Binder was immediately place on the end table in the community lobby for display during inspection 8-22-19

See Attached B

By 11/1/19: The administrator or designated staff person shall check the home weekly to ensure compliance with regulation 2600.123(b). 10/2/19

*[Handwritten signature]*

Legal Entity Representative

*Claudia McIntyre*

Signature

*Claudia McIntyre, ED*

Printed Name and Title

*9-27-19*

Date

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126a - Furnace Inspection

Regulations

2600.

126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The most recent inspection of the home's heating, venting and air conditioning (HVAC) system was completed on 4/18/18.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

McKamish HVAC was notified and came to Artis South Hills on 8-22-19 and annual inspection was performed on day of DHS Annual Inspection 8-22-19. All units operating properly and heating well. Zone boards and thermostats checked. See Attachment C.

EVS Director was educated on the regulation 2600.126(a)(b) and process improvement plan. See attachment D.

Picture of EVS Annual Inspection Binder See attachment E.

Screen shot EVS Director Outlook Calendar for On-going Annual Furnace Inspection scheduled for the 1st Monday of August 2020 then annually thereafter. See Attachment F.

Outlook Calendar of Annual Furnace Inspection scheduled for 1st Monday August 2020 then annually thereafter to Executive Director (screenshot). See attachment G.

Legal Entity Representative

*Claudia McIntyre*  
Signature

*Claudia McIntyre, ED*  
Printed Name and Title

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132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's safe evacuation time as determined by a fire safety expert on 4/2/19 is 12 minutes and 0 seconds. However, the home conducted a fire drill on 7/31/19 at 1:30 a.m. with a 14 minute and 0 second evacuation time.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The Environmental Services Director and Executive Director will review each monthly Fire Drill Record for compliance then each will initial in the Planned Corrective Action Column. If a monthly Fire Drill is out of compliance, this will be noted and that months' Fire Drill will be repeated to ensure compliance.

The Environmental Services Director and Executive Director will take responsibility to ensure this violation is not repeated.

See attached H

By 11/1/19: The administrator will complete the following steps to reduce the safe evacuation to a time specified in writing by a fire safety expert within the past year:

- \* Conduct at least two fire drills a month until the home can meet the safe evacuation time specified in writing by a fire safety expert within the past year, for three consecutive months.
- \* If the home exceeds the safe evacuation time specified in writing by a fire safety expert within the past year, for two consecutive fire drills, the home will add additional staff to the regular schedule and maintain the staffing level at all times. 10/2/19 *[Signature]*

Legal Entity Representative

*Claudia McIntyre*

Signature

Claudia McIntyre, ED

Printed Name and Title

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161d - Dietary Needs

Regulations

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #2 is ordered a mechanical soft diet. However, at approximately 12:25 p.m., resident #2 was observed to have been served a piece of strata which measured approximately 2 1/2" X 2 1/2" and a raw vegetable salad that included 1/2"-1" chunks of tomato.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #2 diet order was changed to Regular Diet, Regular Consistency per Vitas Hospice Orders after eval of residents current condition immediately following DHS Inspection 8-22-19. Resident #2 is consuming a regular consistency diet with no noted difficulties in chewing or swallowing.

Improvement Process:

The Culinary Director receives a Diet Communication Form upon move-in, re-admit and any MD ordered diet changes. The Culinary Director places diet order on Diet Order Audit Sheet. This ensures diet is correct on Culinary Document Sheet. The Culinary Director will audit monthly that all diet orders are correct on the Culinary Document Sheet, MAR, MD order and RASP See attachment I. Any corrective action will be completed at the time of audit. This audit will be reviewed Quarterly for 4 Quarters then reviewed for further need to audit.

Legal Entity Representative

*Claudia McIntyre*

Signature

Claudia McIntyre, ED

Printed Name and Title

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184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #3 is prescribed Haldol 2mg/mL pre-filled syringes 0.5mg (0.25mL) oral every 4 hours as needed for agitation/nausea. However, the prescription label for this medication indicates "Haloperidol OS 0.5mg/0.25cc - Take 0.5mg (0.25ml) sublingual every 4 hours as needed for agitation/nausea."

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

MAR for resident #3 was updated to reflect generic medication (Haloperidol OS) and oral route. See attachment J.

All nurses and med-techs will be re-educated on 10-2-2019 regarding regulation 184(a) with emphasis on medication labels must match the residents MAR, which includes ensuring both generic and name-brand medications are listed when appropriate. See attachment K

Executive Director will coordinate whole house audit with Johnson's Pharmacy of medication labels and MARS to ensure all pharmacy labels match resident MARS by 11-1-2019.

Director of Health and Wellness or designee will conduct on-going monthly audit to ensure compliance.

Legal Entity Representative

*Claudia McIntyre*

Signature

Claudia McIntyre, ED

Printed Name and Title

9-27-19

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185a - Implement Storage Procedures

Regulations

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 #3 is prescribed Roxanol (morphine sulfate) 20mg/mL solution – take 0.25mL sublingually every 3 hours for shortness of breath or pain. At 2:05 p.m., the medication was not available in the home for administration.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Upon discovery, medication was immediately ordered from Johnson’s Pharmacy. Medication was delivered on 8-22-2019.

All nurses and med-techs will be re-educated on 10-2-2019 regarding regulation 185(a) with emphasis that all prescribed medications (routine and as needed) must be available in the home to administer. See Attachment L

Executive Director will coordinate whole house audit with Johnson’s Pharmacy of medication storage areas, MARS and physical orders to ensure all currently ordered medications are available for administration in the home by 11-1-19.

Director of Health and Wellness or designee will conduct on-going audits monthly to ensure compliance.

Legal Entity Representative

*Claudia McIntyre*

Signature

*Claudia McIntyre, ED*

Printed Name and Title

*9-27-19*

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187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #2 is prescribed Ativan Intensol (2mg/ml) – give 0.25ml(0.5mg) SL Every 4 hours PRN/ as needed for anxiety or nausea or sleep disturbance. However, the prescription label on the medication count sheet indicates Lorazepam O.S. 0.5mg/0.25cc – take 0.5mg (0.25mL) sublingually every 4 hours as needed for anxiety/nausea/sleep.

Resident #3 is prescribed Haldol 2mg/mL pre-filled syringes 0.5mg (0.25mL) oral every 4 hours as needed for agitation/nausea. The residents August 2019 medication administration record (MAR) entry for this medication indicates "Haldol 2mg/mL – 0.5mg (0.25mL) q 4 hours PRN Dx: agitation/nausea"

Resident #3 is prescribed Levsin 0.125mg – one tablet sublingually every 4 hours as needed for excess secretions. The resident's August 2018 MAR indicates "Levsin 0.125mg – one tablet sublingual q 4 hours PRN Dx secretions"

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

*see attached sheet*

See Page 10A of 11

Legal Entity Representative

*Claudia McIntyre*

Signature

*Claudia McIntyre, ED*

Printed Name and Title

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MAR for resident #2 was updated to reflect generic medication (Lorazepam OS) and strength /dosage (0.5mg/0.25cc) – take 0.5mg (0.25ml) See attachment M

MAR for resident #3 was updated to reflect “take by mouth every 4 hours as needed. See attachment N

MAR for resident #3 updated to reflect “take 1 tablet sublingually every 4 hours as needed” See attachment N

All nurses and Med techs will be re-educated on 10-2-19 regarding regulation 187(a) with emphasis on ensuring that all medication instructions are clearly written on each residents MAR and that no medical abbreviations (Such as “PO” or “prn”) are used. See attachment O

Executive Director will coordinate whole house audit with Johnson’s Pharmacy to ensure compliance.

Director of Health and Wellness or designee will conduct ongoing monthly audits to ensure compliance.

*Claudia McIntyre 9-27-19*

10/2/19 *g*

231e - No Objection Statement

Regulations

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the home on 5/18/18. The home's "Attachment E Statement of Voluntary Move-in" did not include that the resident did not object to the resident's admission to the secured dementia care unit. The statement was only signed by the resident's responsible party. There was no indication on the document that the resident was unable to sign.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Attachment D of the Move In packet does exist for Artis Senior Living of South Hills move in paperwork that includes a "Statement of Voluntary Move In" for the Resident and 2 witnesses to complete (see attached) and was inadvertently removed by the former Director of Marketing for some residents move ins. Resident #1 is unable to sign the voluntary move in form due to her agitation and confusion as dictated upon admission diagnosis. Form was completed on 8-22-19 to support (see attached). Education to new Director of Marketing and Director of Community Relations regarding complete move in paperwork packet to include Attachment D was completed (see attached education and audit forms). Quarterly audits will be conducted by designee on all new Move Ins to ensure that residents signs the form and/or indicates why the resident is unable to sign and results reported in QA meeting for compliance.

Legal Entity Representative

*Claudia McIntyre*  
Signature

*Claudia McIntyre, ED*     *9-27-19*  
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