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

April 12, 2023

ARTIS SENIOR LIVING OF LOWER MORELAND LLC

RE: ARTIS SENIOR LIVING OF HUNTINGDON VALLEY
2085 LIEBERMAN DRIVE
HUNTINGDON VALLEY, PA, 19006
LICENSE/COC#: 14279

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/15/2023, 02/16/2023, 02/17/2023 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: *ARTIS SENIOR LIVING OF HUNTINGDON VALLEY* **License #**: *14279* **License Expiration**: *07/18/2023*

Address: *2085 LIEBERMAN DRIVE, HUNTINGDON VALLEY, PA 19006*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *ARTIS SENIOR LIVING OF LOWER MORELAND LLC*

Address: *680 AMERICAN AVENUE, SUITE 101, KING OF PRUSSIA, PA, 19406*

Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *196* **Total Daily Staff**: *336* **Waking Staff**: *252*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *02/21/2023*

Inspection Dates and Department Representative

02/15/2023 - On-Site:
02/16/2023 - Off-Site:
02/17/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Whole Home* **Capacity**: *72* **Residents Served**: *70*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *70* **Have Physical Disability**: *0*

Inspections / Reviews

02/15/2023 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/11/2023*

Inspections / Reviews *(continued)*

03/16/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/12/2023*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *03/21/2023*

03/17/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/12/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *04/14/2023*

04/12/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *04/12/2023*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at approximately [redacted], resident 1 fell on the home's patio while attempting to climb a fence and was sent to the emergency room for evaluation. The resident was diagnosed with a abrasions to their head, shoulder, wrist and knee. The home did not report this incident to the department.

Plan of Correction ***Accept (MS - 03/17/2023)***

On 2/16/23 The Executive Director provided training to all the nurses on reportable incidents.

The Director of Health and Wellness or designee will audit incident reports daily to ensure any reportable incidents are reported.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

42b - Abuse

2. 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 [redacted], resident 1 attempted to climb a fence by pushing a patio chair against the fence in the home's courtyard. Resident 1 fell while attempting to climb the chair or the fence, and sustained several abrasions to the face, shoulder, wrist and knee. The fall was unwitnessed by staff but resident was found face down on the ground. There was nothing put in place to protect or prevent the resident from attempting to climb the fence even though the resident exhibited problematic exit seeking behavior and aggressive behavior prior to the incident on [redacted]. Resident 1's file documents that on [redacted], the resident tried to climb the fence to escape the home and became physically aggressive when redirected and on [redacted], the resident was exit seeking and punched a glass door when staff attempted to redirect. The resident sustained a skin tear to their hands and arm while staff were attempting to redirect resident from the door on [redacted].

On [redacted], resident 2 eloped from the home and was found in a family member's backyard. The resident used the door code to exit the home into the courtyard and climb over the fence outside. The home was not aware that the resident 2 had eloped until the resident's family called the home to inform them that resident 2 was found in their back yard, which is 1.5 miles from the facility. The home was aware that resident 2 could use the door codes as the resident had used the code to exit the secure dementia care unit into the front lobby on [redacted]. The codes on all doors, except to exit into the lobby, are not disguised.

42b - Abuse *(continued)*

Plan of Correction ***Accept (MS - 03/17/2023)***

On 2/21 training was provided by Executive Director to all staff on safety interventions and how to manage residents who cannot be redirected. To ensure that residents will not be neglected when they have unmanageable behaviors. Safe Management Techniques re-iterated to include sending a resident out to a behavioral health unit if unable to redirect for safety reasons.

The Executive Director of designee will be updated on a daily basis at our morning meeting by the Director of Health and Wellness or their designee on all incidents. This will be an ongoing update indefinitely.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

51 - Criminal Background Check

3. 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 A was hired on [redacted] and does not have a criminal background check.

Plan of Correction ***Accept (MS - 03/17/2023)***

2600.51 Our hiring policy requires every staff member to have criminal background checks in accordance with the Older Adult Protective Services Act completed prior to start date.
Staff Member A has had a criminal background check done since this survey.
Every staff member since "Staff person A" has had a criminal history check prior to start date. All current staff files have since been audited to ensure all criminal history checks have been completed.
A new hire checklist has been implemented as of 2/17.
The Executive Director or designee will use the new hire checklist to ensure all documents have been received prior to any new staff member starting.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

65g - Annual Training Content

4. 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:

Description of Violation

Staff person A did not receive training in fire safety and emergency preparedness during training year 2022.

Plan of Correction ***Accept (MS - 03/17/2023)***

Staff person A is a PRN employee and received training on [redacted] to complete for 2023.
On 2/17/2023 All Department Heads were retrained on Fire Safety and Emergency Preparedness requirements for all staff.

65g - Annual Training Content (continued)

Executive Director or designee will receive emailed monthly updates from the Director of Health and Wellness or designee of training needs, to ensure ongoing compliance of mandatory training. This update will occur on the first of every month.
Training needs will be tracked by using a training spreadsheet on each staff member and updated monthly .

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

141b2 - Medical Evaluation Changes

5. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident 1 began hospice on [redacted] and did not have a new medical evaluation completed.

Plan of Correction ***Accept (MS - 03/17/2023)***

Resident 1 is no longer in the community.

Director of Health and Wellness or designee will audit all current residents and udpate any medical evaluations needed. These audits started on 2/17 and ended on 2/21/2023.
The Director of Health and Wellness or designee will audit resident charts as needed when incidents or health changes occur. A dry erase board is utilized for resident health changes for all nurses, and is located in the nursing office.
The Director of Health and Wellness or designee will audit charts weekly to ensure compliance of updated DME's.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

185a - Implement Storage Procedures

6. 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

The controlled substance count sheet for resident 2 for the controlled substance received on 8/1/22 does not list the name of the medication and the dosage.

The controlled substance count sheet for Clonazepam 0.5 MG for resident 2 received on 10/8/22 is missing the sheet 3 of 3.

Plan of Correction ***Accept (MS - 03/17/2023)***

2600.185.a
On 2/16/23 the Executive Director started training All nurses and med techs on proper handling of controlled

185a - Implement Storage Procedures (continued)

substances. This includes proper labeling for controlled substances. This training concluded on 2/19 with all nurses and med techs being trained.
Director of Health and Wellness audited all controlled substance count sheets on date of inspection 2/15/2023.
Director of Health and Wellness or designee will continue to audit controlled substance count sheets on a daily basis.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

201 - Positive Interventions

7. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident 1 was exit seeking on [redacted] and tried to climb a fence outside the home. The resident fell and was injured. Prior to this fall, there are two documented incidents where resident 1 was exit seeking and became violent when redirected. On [redacted] resident 1 attempted to climb the fence to exit the home. After this incident, there was nothing put into place to prevent resident 1 from attempting to climb the fence again. On [redacted], when resident 1 fell trying to climb the fence, direct care staff were serving dinner to the other residents and there was no staff person outside with resident 1. According to the resident's assessment dated [redacted], the resident requires total supervision. According to the support plan dated [redacted], hourly checks are to be completed as the plan for the resident's supervision. There is no proof hourly checks were being completed.

The home is was aware that resident 2 could use the door codes to open the doors in the secured unit. No measures were taken to disguise the codes for the doors that lead outside. On [redacted], resident 2 was able to leave the home and go to a family member's house. According to resident 2's assessment dated [redacted] the resident requires total supervision. According to the support plan dated [redacted] hourly checks would be completed as the plan for the resident's supervision. There is no proof hourly checks were being completed.

Plan of Correction ***Accept (MS - 03/17/2023)***

2600.201
On 2/16/23 the Executive Director started Safe management techniques training and ongoing until everyone was trained. The training was completed on 2/21/23 when every staff member completed this training.
Resident 1 and Resident 2 are no longer residing in our community.
The Executive Director of designee will work on immediate safety plans for a resident who is identified as a safety risk.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

225c - Additional Assessment

8. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident 1’s most recent assessment was completed on [redacted]. The resident began hospice on [redacted] and a new assessment was not completed.

Plan of Correction ***Accept (MS - 03/17/2023)***

2600.225.c
Resident 1 is no longer living in the community so a new assessment cannot be completed.
The Executive Director provided training on 2/20/23 through 2/24/23 for all nurses, Director of Health and Wellness and Assistant Director of Health and Wellness.
Director of Health and Wellness or designee will complete audits on existing residents and also audit resident charts when a change of status occurs to ensure compliance. These audits were completed as of 2/21/23.
A dry erase board is utilized for resident health changes for all nurses, and is located in the nursing office in which the Director of Health and Wellness or designee will monitor daily.
The Director of Health and Wellness or designee will audit charts weekly to ensure compliance of updated assessments.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)

253c - Records Log

9. Requirements

2600.
253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident’s name, record number, birth date, admission date and discharge date.

Description of Violation

Resident 1's RASP dated [redacted]2 and resident 2's RASP dated [redacted], indicate that each resident was to have hourly checks completed by direct care staff for supervision needs. Staff report that they would document these hourly checks in a log or book. The home could not provide record of these checks and reported that the logs are destroyed after an unknown amount of time. The home does not have a log of the destruction of these records.

Plan of Correction ***Accept (MS - 03/17/2023)***

2600.253.c
The Executive Director provided training on retaining records on 2/20/23 and completed on 2/24/2023 to all nurses, Director of Health and Wellness and Assistant of Health and Wellness.
Records policy updated to include hourly checks be kept from survey to survey.
The Executive Director of designee will ensure all resident hourly checks be retained from survey to survey.

Licensee's Proposed Overall Completion Date: *03/16/2023*

Implemented (MS - 04/12/2023)