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

June 23, 2023

[redacted]
SENIOR LIVING OF LOWER MAKEFIELD LLC
[redacted]

RE: ARTIS SENIOR LIVING OF YARDLEY
765 STONY HILL ROAD
YARDLEY, PA, 19067
LICENSE/COC#: 14650

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/22/2023, 05/23/2023 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARTIS SENIOR LIVING OF YARDLEY* **Licen e #**: *14650* **Licen e Expiration**: *04/28/2024*

Address: *765 STONY HILL ROAD, YARDLEY, PA 19067*

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

Administrator

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

Legal Entity

Name: *SENIOR LIVING OF LOWER MAKEFIELD LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *08/18/2018* **I ued By**: *Lower Makefield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *114* **Waking Staff**: *86*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/23/2023*

Inspection Dates and Department Representative

05/22/2023 On Site [redacted]

05/23/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *72* **Residents Served**: *57*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *57* **Have Physical Disability**: *0*

Inspections / Reviews

05/22/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/16/2023*

06/21/2023 - POC Submission

Submitted By [redacted] **Date Submitted**: *06/23/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/24/2023*

Inspections / Reviews *(continued)*

06/23/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On May 23, 2023, the home's License Inspection Summary, dated April 11, 2022, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 06/21/2023)***

On day of inspection, the April 11, 2022 License inspection summary was posted by the Executive Director.
The Executive Director of designee will ensure an updated LIS is posted in a conspicuous and public place after each new inspection. In this building, the license inspection summary is posted in the lobby.
During daily rounds, starting 5/23/2023, the Executive Director or designee will ensure a copy of the most current License inspection summary is posted in the lobby.
Attached is a picture of the the LIS from 4/11/2022

Licensee's Proposed Overall Completion Date: *06/14/2023*

Implemented [redacted] 06/23/2023)

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] 2023, staff member A was outside and saw someone walking away from the community, towards the sidewalks leading to the road. Staff member A thought it looked like one of the memory care residents but was not sure. Staff member A immediately went into the building and asked if all of the residents were accounted for. The facility did a resident check, and staff member B went to get her/him keys to drive in the area to see if it was indeed one of the residents. After about 10–15 minutes, the staff members realized resident 1 was unaccounted for and then called 911 for the Lower Makefield police. Staff member B drove by the Giant store about two blocks away from the community and saw what she/he thought looked like the resident walking into the grocery store. Staff member B went inside the store and found resident 1. Resident 1 wanted to shop for a few items. Staff member B stayed with the resident while the resident shopped and paid for the items. Staff member B then immediately brought resident 1 back to the building. The resident was physically assessed; no injuries were noted, and vital signs were within normal limits. Resident 1 stated "The gate was open". Normal operation of the gates sounds and alarms were not secure. The facility hired a contractor to fix the gates.

Plan of Correction ***Accept ([redacted] 06/21/2023)***

On the day of the resident elopement, [redacted]/2023, we immediately started hourly gate checks to ensure the gate was secured until we could have someone come to check the gate for any malfunction. On [redacted]/2023 we immediately assigned a one on one care aid with this resident any time [redacted] wanted to walk outside until we had the gate checked for any malfunction.
We have revised our hourly checks protocol which started on [redacted] 2023 to include gate checks, so every hour someone was pushing/pulling on gates to ensure they were locked.
We called the security company which came the next morning [redacted]/2023 to check for malfunction. They replaced

42b - Abuse (continued)

the gate lock on [redacted]/2023. Gate codes were changed to ensure safety.
Training was provided by the Executive Director on [redacted]/2023 and again on [redacted]/2023 to ensure all staff were completely trained on changes to hourly checks to include gate checks, elopement procedures, and training points regarding the elopement. We emphasized that if any staff member thinks they see someone who looks like a resident leaving our secured area, they should immediately go to that person instead of questioning and allowing aluable minutes to pass. This practice would have kept this resident from entering unsafe areas.
The Executive Director or designee will ensure the gates leading to unsafe areas are secure during daily rounds.

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented [redacted] 06/23/2023)

82c Locking Poisonous Materials

3. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On May 23, 2023, there was a tube of toothpaste with a manufacturer's label indicating "Keep out of reach of children; please contact the Poison Control Center right away, unlocked, unattended, and accessible to resident 2. Not all the residents of the home, including resident 2, have been assessed as being capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] 06/21/2023)***

On day of inspection, when the tube of toothpaste was found, it was immediately locked up.
Training was provided on 5/26/2023 by the Executive Director for the care giver and Nurse who left out the toothpaste, to lock up poisonous materials so they are not accessible for our residents who cannot safely use or avoid poisonous materials.
Effective 5/23/2023, The Director of Health and Wellness or designee will ensure during their daily rounds that poisonous materials are locked in the residents cabinet.
see attached training

Licensee's Proposed Overall Completion Date: *06/14/2023*

Implemented [redacted] - 06/23/2023)

85e - Trash Outside Home

4. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On May 23, 2023, there was a blue plastic container, a black carp, wood pallets, kitchen carts, cardboard, and miscellaneous pieces of trash outside the facility in the trash container area.

85e - Trash Outside Home (continued)

Plan of Correction ***Accept (MJ 06/21/2023)***

On day of inspection, the Director of Environmental Services, cleaned up the debris that was on the outside of the dumpster and placed it inside the covered dumpster.
Training was provided on 5/23/2023 by the Executive Director to the Director of Environmental Services regarding the 2600.85.e regulation since he is the person to manage the outside trash area.
Effective 5/23/2023, During the daily rounds, the Director of Environmental services or designee will ensure there is no trash or debris lying on the outside of the dumpster.
See attached.

Licensee's Proposed Overall Completion Date: *06/14/2023*

Implemented [redacted] - 06/23/2023)

103i - Outdated Food

5. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On May 23, 2023, there were two bags of waffles and one bag of unlabeled, undated flat bread in the main kitchen freezer.

Plan of Correction ***Accept [redacted] 06/21/2023)***

On day of inspection, the two bags of waffles and one bag of flat bread were discarded.
Training provided on 6/14/2023 by the Director of Culinary Services and Executive Director to the culinary team to ensure food is in original packaging, and if opened, has labels with date opened and used within time frame specified on the packaging. If not in original packaging, must have date opened, and a date to be discarded.
The Director of Culinary Services or designee starting 5/23/2023 will ensure food is properly labeled and a discard date is specified on a food product. The Director of Culinary Services or designee will inspect food products daily to ensure proper labeling is followed.
see attached training

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented [redacted] - 06/23/2023)

107b - Emergency Procedures

6. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:
1. Contact information for each resident s designated person.

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person.

Plan of Correction ***Accept ([redacted] - 06/21/2023)***

On day of inspection, the residents emergency contact information for each resident was placed in the written

107b - Emergency Procedures (continued)

emergency procedures manual.
The emergency contact information for each resident will be updated after every new resident Move in and Move out.
Effective 5/23/2023, The Executive Director of designee will ensure the emergency binder will be updated weekly with resident emergency contact information or when resident census changes.
see attached

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented ([redacted] - 06/23/2023)

123b - Emergency Procedures Posted

7. Requirements

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

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 06/21/2023)***

On day of inspection, the emergency procedures were posted in the lobby by the Executive Director. A copy is kept in the Emergency Response Manual.
Effective 5/23/2023, The Executive Director of designee will ensure the emergency procedures are posted when performing daily rounds. The Executive Director or designee will update the emergency procedures yearly or if any changes need to be made sooner.
see attached

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented ([redacted] - 06/23/2023)

162c - Menus Posted

8. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for weeks one and two of May 2023 were posted. However, the menus for the current week, starting 05/21/2023 to 05/27/2023, and one week in advance, starting 05/28/2023 to 06/03/2023, with the specific food being served at each meal, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 06/21/2023)***

Effective 5/23/2023, We eliminated the numbered weeks menu rotation and now using a current week and next week menu signage.

162c - Menus Posted (continued)

The menus are and will continue to be posted in our menu box near the dining room for all residents and families to see.

The Director of Culinary Services or designee will ensure during their daily rounds that the menus are of current week and the following week.

See attached.

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented [redacted] - 06/23/2023)

183a - Original Containers and Injections

9. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On May 23, 2023, the [redacted] TAB 0.5 MG prescribed for resident 3 was in a blister card. The foil on the back of one of the pills had ripped.

Plan of Correction ***Accept [redacted] - 06/21/2023)***

On day of inspection 5/23/2023 the medication which had the torn blister card was appropriately discarded with two nurse verification.

Training was provided by the Executive Director and the Director of Health and Wellness to our medication technicians and all nurses on 5/24, 5/25, and 5/26 regarding topics of discarding loose pills in cart, checking pill pack integrity to make sure nothing is torn open, not taping the pill pack if torn, and training on a new protocol/order for a second signature to verify glucometer readings for accuracy. This will help reduce human error when transcribing.

The Director of Health and Wellness or designee will audit med carts on a weekly basis, to ensure compliance. The Director of Health and Wellness or designee will also perform spot checks starting 5/24/2023 at different times during the week.

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented [redacted] - 06/23/2023)

183e - Storing Medications

10. 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 May 23, 2023, there was half a loose pill in one of the medicine cart drawers.

183e - Storing Medications *(continued)*

Plan of Correction ***Accept (MJ - 06/21/2023)***

On day of inspection 5/23/2023, the loose pill was removed from the medicine cart and disposed of appropriately, two nurses signed off.
Training was provided by the Executive Director and the Director of Health and Wellness to Medication technicians and all nurses on 5/24, 5/25, and 5/26 regarding topics of discarding loose pills in cart, checking pill pack integrity to make sure nothing is torn open, not taping pill pack if torn, and new protocol/order for a second signature to verify glucometer readings are accurate when transcribing into MAR.
A new item "cart sweep" has been added to the daily narcotic count record to audit for loose pills and ensure all backing of the pill packs are intact. This will ensure that each shift has checked for compliance in these areas.
The Director of Health and Wellness or designee will audit med carts on a weekly basis starting 5/24/2023, to ensure compliance. The Director of Health and Wellness or designee will also perform spot checks different times during the week.
see attached

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented ([redacted] - 06/23/2023)

185a - Implement Storage Procedures

11. 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

On May 22, 2023, resident 4's glucometer reads [redacted] and the medication records read [redacted]

Plan of Correction ***Accept ([redacted] 06/21/2023)***

Training was provided by the Executive Director and Director of Health and Wellness on dates of 5/24, 5/25, and 5/26 to ensure we train every med tech and nurse on having two staff people sign off on a blood glucose reading.
We realized that we had to revise our current practice which is having only one person sign off on blood glucose documentation. To decrease the chances of human error transcribing the wrong glucometer reading number, We have revised our practice to now include two people to sign off on a glucometer reading. This practice started on 6/12/2023. Physician orders now require two people to sign off on a blood glucose reading.
The Director of Health and Wellness or designee will audit the glucometer readings daily starting 5/23/2023 to ensure compliance. After 30 days of error free readings, glucometer audits will then decrease to weekly audits.

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented [redacted] - 06/23/2023)

227d - Support Plan Medical/Dental

12. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident 5, dated [redacted] 2023, indicates the resident has a need for a [redacted] diet. The resident's support plan, dated [redacted] 2023, does not document how this need will be met.
The assessment for resident 6, dated [redacted], 2023, indicates the resident has a need for [redacted] diet. The resident's support plan, dated [redacted], 2023, does not document how this need will be met.
The assessment for resident 7, dated [redacted], 2023, indicates the resident has a need for a diet with [redacted] and [redacted]. The resident's support plan, dated [redacted] 2023, does not document how this need will be met.

Plan of Correction ***Accept ([redacted] - 06/21/2023)***

A training was provided on 5/23/2023 by the Executive Director to the Director of Health and Wellness and the Assistant Director of Health and Wellness on this regulation.
A support plan audit which was started on 5/24 and completed on 5/29 was done on all current residents to identify who was out of compliance. Resident 5, resident 6, and resident 7 were corrected. Any diets that were found to be in need of any special diets have been corrected and how this need will be met.
Going forward all diets will match physician orders and also document how the needs will be met.
The Director of Health and Wellness or designee will audit support plans monthly to ensure any new residents and residents with diet changes will reflect on individual support plans.

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented [redacted] - 06/23/2023)

234a - Admission Support Plan

13. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 1, was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] 2023. However, the resident's initial support plan was completed on [redacted] 2023.
Resident 5, was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] 2023. However, the resident's initial support plan was completed on [redacted] 2023.
Resident 7, was admitted to the Secure Dementia Care Unit (SDCU) on [redacted], 2023. However, the resident's initial support plan was completed on [redacted], 2023.
Resident 8, was admitted to the Secure Dementia Care Unit (SDCU) on [redacted], 2022. However, the resident's initial support plan was completed on [redacted] 2022.

Plan of Correction ***Accept [redacted] - 06/21/2023)***

A training was provided on 5/23/2023 by the Executive Director to the Director of Health and Wellness and to the

234a - Admission Support Plan (continued)

Assistant Director of Health and Wellness to have admission support plans completed within 72 hours.
An audit was started on 5/24 and completed on 5/29 to identify which residents support plans were out of compliance. Going forward, all resident support plans will be in compliance.
The Director of Health and Wellness or designee will audit support plans starting 5/23/2023 within 72 hours of any new admissions to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented [redacted] - 06/23/2023)