pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ARTIS SENIOR LIVING OF LOWER MORELAND LLC**
LEGAL ENTITY

To operate **ARTIS SENIOR LIVING OF HUNTINGDON VALLEY**
NAME OF FACILITY OR AGENCY

Located at **2085 LIEBERMAN DRIVE, HUNTINGDON VALLEY, PA 19006**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **72** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 72**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 11, 2025** until **September 11, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142791**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 11, 2025

President and CEO
Artis Senior Living of Lower Moreland LLC

RE: Artis Senior Living of Huntingdon Valley
2085 Lieberman Drive
Huntingdon Valley, Pennsylvania 19006
License #: 142791

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection August 27, 28, and September 4, 2024 and November 4, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 142790 dated July 18, 2024 to July 18, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(1) ;(2) ;(3) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from March 11, 2025 to September 11, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *ARTIS SENIOR LIVING OF HUNTINGDON VALLEY* **License #**: *14279* **License Expiration**: *07/18/2025*

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:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/13/2016* **Issued By**: *Township of Lower Moreland*

Staffing Hours

Resident Support Staff: - **Total Daily Staff**: *NaN* **Waking Staff**: *NaN*

Inspection Information

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

Reason: *Complaint, Incident, Monitoring* **Exit Conference Date**: *09/04/2024*

Inspection Dates and Department Representative

08/27/2024 - On-Site:
08/28/2024 - On-Site:
09/04/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *All areas* **Capacity**: *72* **Residents Served**: *55*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *55* **Have Physical Disability**: *0*

Inspections / Reviews

08/27/2024 - Partial

Lead Inspector: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *09/29/2024*

10/08/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *10/13/2024*

10/17/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *11/07/2024*

02/14/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *12/06/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 8/27/2024, at 1:15 pm, resident records were unlocked, unattended, and accessible on a bed in a "staff only" room at the temporary emergency relocation site.

Plan of Correction ***Accept (- 10/17/2024)***

In response to the violation on 08/27/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken by the Executive Director to secure the records and the staff only room at temporary emergency relocation site.

On 08/28/2024 the violation was reviewed with Director of Health and Wellness and education on the regulation was provided to all staff. On 08/27/2024 the Executive Director and Director of Health and Wellness implemented processes to monitor the security of resident records. Monitoring of security remained in place until our departure from the temporary community on 09/04/2024. Monitoring of security of confidentiality of resident records remain in place our or home community. The monitoring is 24 hours a day, 7 days a week. This monitoring remains ongoing and is indefinite.

On 09/04/2024 the temporary emergency location was exited and re-entry was made into Artis Senior Living of Huntingdon Valley. All resident's records have been returned to the community's keypad secured nurse's station. Monitoring of the securing of resident records is permanent.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (- 02/11/2025)

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 , at approximately staff person A who was providing care and assisting residents at the home's temporary emergency relocation site, took three pictures of resident 1 and posted the images on personal social media account. One photograph was the resident's informational whiteboard with the resident's nickname, name of staff person, goals stating "Go to bed early" and a clock. it was posted with a caption stating "This is my favorite part of work" with a laughing crying emoji. The second photograph shows resident 1 on the floor in a hospital gown in front of a wheelchair. The resident is holding onto the wheelchair with of look of discomfort. It was posted with a caption stating "This is my favorite part of work" with a laughing crying emoji . The 3rd photograph shows the resident seated in the wheelchair with their eyes closed and holding their head. It was posted with a caption stating "literally makes me wanna quit my job" with a straight-faced emoji and a laughing crying emoji.

The posting was reported by the home's security team. The staff person was terminated.

42b - Abuse (continued)

Plan of Correction ***Accept (█ - 10/17/2024)***

In response to the violation on █ by the Pennsylvania Bureau of Human Service Licensing, action was taken on 09/01/2024, which is when the Executive Director was made aware of the violation.
On 09/01/2024 the incident was reviewed by the Executive Director and the Director of Health and Wellness. The staff member was terminated on █ On 09/03/3024 all staff members of Artis Senior Living of Huntingdon Valley were re-educated on codes pertaining to the violation. Prevention of resident abuse will be maintained with a combination of monthly training of all staff members, weekly interviews of residents conducted by The Director of Health and Wellness, and The Executive Director. The implementation of the abuse prevention program began of 09/30/2024 Staff will continue to be educated via planned monthly in-servicing and annual training sessions conducted the Executive Director, Health and Wellness Director & Industry professions of the topic of abuse prevention (i.e. hospice professions).

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (█ - 12/19/2024)

42s - Privacy

3. Requirements

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 █ at approximately █ PM, photographs and personal information of resident 1 were posted on a social media platform by staff person A. The photographs were taken by staff person A. The photos depicted the resident in a hospital gown, seated on the floor, and in a wheelchair, showing obvious signs of distress or discomfort, as well as personal information regarding the resident.

Plan of Correction ***Accept (█ - 10/17/2024)***

In response to the violation on █ by the Pennsylvania Bureau of Human Service Licensing, action was taken on 09/01/2024, which is when the Executive Director was made aware of the violation.
On 09/01/2024 the incident was reviewed by the Executive Director and the Director of Health and Wellness. The staff member was terminated on █. On 09/03/3024 all staff members of Artis Senior Living of Huntingdon Valley were re-educated on codes pertaining to the violation. Protection of resident rights will be maintained with a combination of monthly training of all staff members, weekly interviews of residents conducted by The Director of Health and Wellness, and The Executive Director. The implementation of the violation of resident privacy rights program began of 09/30/2024 Staff will continue to be educated via planned monthly in-servicing and annual training sessions conducted the Executive Director, Health and Wellness Director. Monitoring of staff use of cell phones began of 09/04/2024. Monitoring if conducted by the Executive Director, Director of Health and Wellness, Director of Sales and Marketing, Director of Environmental Services, Activities Director, and Charge Nurse,

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (█ - 12/19/2024)

42s - Privacy *(continued)*

51 - Criminal Background Check

4. 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

The home does not have completed background checks for contracted or substitute staff members working at the temporary emergency relocation site.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/04/2024 action was taken by the Executive Director to obtain background checks for contracted or substitute staff members. On 09/08/2024 an audit of contracted and substitute staff member files was conducted by the Director of Business Services. An additional audit of newly contracted and substitute staff members will be conducted by the Executive Director, as they are contracted. On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing criminal history checks. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (- 02/04/2025)

54a - Direct Care Staff

5. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/04/2024 an audit of Staff member B's employee file was conducted. The employee's now contains high school diploma, a copy of the Pennsylvania Direct Care Staff, a copy of the pre-employment drug screening and pre-employment background check.
On 09/04/2024 an audit of Staff Member C's employee file was conducted. It was discovered the file did not contain a copy of the pre-employment background check. The Executive Director contacted the Artis Senior Living corporate office and obtained a copy of the background check. The background check was added to the employee file.
On 09/09/2024 the Business Services Director conducted and audit of all employee files to ensure they all contain a copy of their high school diploma or equivalent, a copy of the Pennsylvania Direct Care Certificate, a copy of the

54a - Direct Care Staff (continued)

pre-employment drug screening, and a copy of the pre-employment background check. An additional audit was conducted by the Executive Director.
In the future, an initial audit of new hire files will be conducted by the Director of Business Services. Upon completion of the file, and additional audit was conducted by the Executive Director.
On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (█ - 12/19/2024)

62 - Contact List

6. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person C, the administrator, does not maintain a list of substitute, agency staff and contracted staff persons.

Plan of Correction ***Accept (█ - 10/17/2024)***

On 09/04/2024 immediate action was taken by the Executive Director to update the list of names, addresses and telephone numbers to include all administration, staff persons, substitute, contracted and agency staff persons. Daily edits are made to by the concierge. The list is then reviewed by the Director of Business Services and stored in the business office. These audits will be conducted on a bi-weekly basis and are ongoing and indefinite.
On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (█ - 02/04/2025)

65a - FS Orientation 1st Day

7. 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.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

Staff person A, 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 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, and telephone use and notification of emergency services.

Staff person B, 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 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, and telephone use and notification of emergency services.

Plan of Correction ***Accept ([redacted] - 10/17/2024)***

On 09/04/2024 immediate action was taken by the Executive Director to enforce the Artis Senior Living of Huntingdon Valley orientation protocol. Orientation is conducted as a joint effort between The Executive Director, The Director of Health and Wellness, The Director of Business Services, The Director of Sales and Marketing, The Director of Culinary Services, The Director of Environmental Services, The Director of Lifestyle Enrichment and The Director of the Artis Way.
Orientation includes but is not limited to 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 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, and telephone use and notification of emergency services.
On 09/08/2024 an audit of all employee files was conducted to ensure all current staff had received orientation and that orientation addressed the required topics. Implementation of orientation protocols will be ongoing and indefinite.
On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director. An audit of new hire employee files will be conducted, by the Executive Director, after each new hire.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented ([redacted] - 12/19/2024)

65b - Rights/Abuse 40 Hours

8. 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).

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

4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed [redacted] 40th scheduled work hour on or about [redacted]. 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), and reporting of reportable incidents and conditions.

Staff person B completed [redacted] 40th scheduled work hour on or about [redacted]. 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), and reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 10/17/2024)***

On 09/04/2024 immediate action was taken by the Executive Director to enforce the Artis Senior Living of Huntingdon Valley orientation protocol. Orientation is conducted as a joint effort between The Executive Director, The Director of Health and Wellness, The Director of Business Services, The Director of Sales and Marketing, The Director of Culinary Services, The Director of Environmental Services, The Director of Lifestyle Enrichment and The Director of the Artis Way.

Orientation includes but is not limited to 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), and reporting of reportable incidents and conditions. 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 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, and telephone use and notification of emergency services. Staff Member A has subsequently been terminated as employee at Artis Senior Living of Huntingdon Valley.

On 09/06/2024 Staff Member B completed the Pennsylvania Direct Care Certification.

Within 24 hours of the conclusion of orientation, an audit of all files of direct care staff persons, ancillary staff persons, substitute personnel and volunteers, completing orientation will be conducted by the Executive Director. The audit will be to confirm the orientee completed 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), and reporting of reportable incidents and conditions.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented ([redacted] - 12/19/2024)

65d - Initial Direct Care Training

9. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   vi. Implementation of the initial assessment, annual assessment and support plan.
   vii. Nutrition, food handling and sanitation.
   viii. Recreation, socialization, community resources, social services and activities in the community.
   ix. Gerontology.
   x. Staff person supervision, if applicable.
   xi. Care and needs of residents with special emphasis on the residents being served in the home.
   xii. Safety management and hazard prevention.
   xiii. Universal precautions.
   xiv. The requirements of this chapter.
   xv. Infection control.
   xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test, complete training that included a demonstration of job duties, followed by supervised practice.

Direct care staff person B, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test, complete training that included a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Accept ([redacted] - 10/17/2024)***

On 09/08/2024 an audit of all employee files was conducted by the Executive Director and The Director of Business Services. The audit was to confirm that prior to orientation, all employees have completed The Pennsylvania Direct Care Certification (where applicable).
Staff Member A has subsequently been terminated as employee at Artis Senior Living of Huntingdon Valley.
On 09/06/2024 Staff Member B completed the Pennsylvania Direct Care Certification.
The requirement of the completion of the Pennsylvania Direct Care Certification is ongoing and indefinite.

On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing criminal history checks. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director. Included in this audit is a check of staff files for completed DHS DC certification. The check for this certification will also be included in the check, conducted by the Executive Director, of every new hire file, immediately following initial hire date.

Licensee's Proposed Overall Completion Date: *10/13/2024*

65d - Initial Direct Care Training *(continued)*

Implemented (█ - 02/04/2025)

65e - 12 Hours Annual Training

10. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person B received no hours of annual training in training year 2023.

Plan of Correction ***Accept (█ - 10/17/2024)***

The Executive Director has taken immediate action to implement a plan to ensure all care staff persons have at least 12 hours of annual training relating to their job. There will be 3 opportunities per month provided via either, professional partners, paid service providers, or Artis professionals. The requirement is that each employee attend at least one of the provided sessions. Implementation of this program will be ongoing and indefinite.
On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director.
Monthly audits of staff files for completed required staff trainings will be conducted. The audit will be conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (█ - 02/04/2025)

65f - Training Topics

11. 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 B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence,

65f - Training Topics (continued)

malnutrition and dehydration, safe management techniques , and personal care service needs of the resident, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2023.

Plan of Correction ***Accept (█ - 10/17/2024)***

On 10/09/2024, 10/10/24, & 10/11/2024 all direct care staff received training regarding residents who are assessed as capable of self-administering medications, how self-administered medications are to be stored in resident rooms, what staff should be aware of or looking for in resident rooms for residents who self-administer medications, and what, how and who to report to if medications are observed unlocked in resident rooms. This training was conducted by the Director of Health and Wellness, and the Executive Director.

On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director. Monthly audits of staff files for completed required staff trainings will be conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (█ - 02/04/2025)

65g - Annual Training Content

12. 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 B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable during training year 2023.

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept (█ - 10/17/2024)***

The Executive Director has taken immediate action to implement a plan to ensure all care staff persons have at least 12 hours of annual training relating to their job. There will be 3 opportunities per month provided via either, professional partners, paid service providers, or Artis professionals. The requirement is that each employee attend at least one of the provided sessions. There will be quarterly sessions for the 6-hour dementia care training. All staff members will be required to attend at least one of the offered sessions, to completion. The training will be conducted by The Executive Director, The Director of Health and Wellness, The Director of Business Services, The Director of Sales and Marketing, The Director of Culinary Services, The Director of Environmental Services, The Director of Lifestyle Enrichment and The Director of the Artis Way.

On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director. Monthly audits of staff files for completed required staff trainings will be conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (█ - 02/14/2025)

82c - Locking Poisonous Materials

13. 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 8/27/2024 at 10:40 AM, at the temporary emergency relocation site, a tube of Medline Remedy specialized prevention silicone cream, a bottle of Fresh Moment mouth wash, and a tube of Crest Complete toothpaste, all with a manufacturer's label indicating "if swallowed contact poison control", were unlocked, unattended, and accessible to residents in room 312.

At 10:43 AM zinc oxide with a manufacture's label indicating "if swallowed contact poison control", was unlocked, unattended, and accessible to residents in room 314.

All the residents of in the home have not been assessed as capable of recognizing and using poisons safely.

Repeat Violation: 9/11/2023

Plan of Correction ***Accept (█ - 10/17/2024)***

On 08/27/2024 the Executive Director took immediate action to secure all poisonous materials from all resident's rooms. All materials were then locked, attended to and rendered inaccessible to residents. The Director of Health and Wellness conducted a re-education to all staff of code 82c. - Locking Poisonous Materials.
Protocol now dictates an addition check, by care staff, be conducted , 3 times a day, of residents room for poisonous materials. These checks are conducted at 8AM, 1PM and 7PM. Care staff members of the assigned residents then sign off once checks are completed. The check list is monitored daily by the Director of Health and Wellness, and the charge nurse. Secondary checks of resident rooms are conducted daily by the Executive Director, Director of Health

82c - Locking Poisonous Materials (continued)

and Wellness, and the charge nurse. These checks will be ongoing and indefinite.

On 10/09/2024, 10/10/2024, 10/11/2024 additional training was conducted with all staff responsible for completing, auditing of resident areas for poisons. Training was conducted by the Executive Director and Director of health and Wellness. The topic covered was 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.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (- 12/19/2024)

85a - Sanitary Conditions

14. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/27/2024 at 10:41 AM at the temporary emergency relocation site, a used wash rag with a light brown stain was hanging on the toilet grab bar of room 312. This room was occupied by two residents. .

On 8/24/2024 during the early AM med pass, resident 2's glucometer was used to take resident 3's blood glucose level.

Plan of Correction ***Accept (- 10/17/2024)***

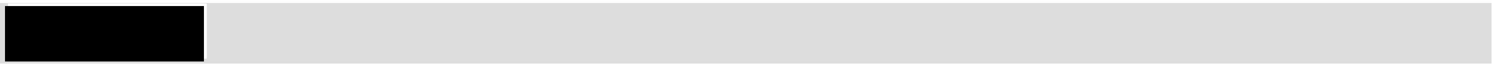
On 08/272024 immediate action was taken by the Executive Director. The wash rag was immediately removed from the resident's room, and the staff member was immediately re-educated on the importance of maintaining sanitary conditions.

On 09/10/2024 additional training for rendered to all care staff as to code 85a by the Director of Health and Wellness. Training will be provided annually as a reminder of the importance of maintaining sanitary conditions in the care home. This training will be ongoing and indefinite.

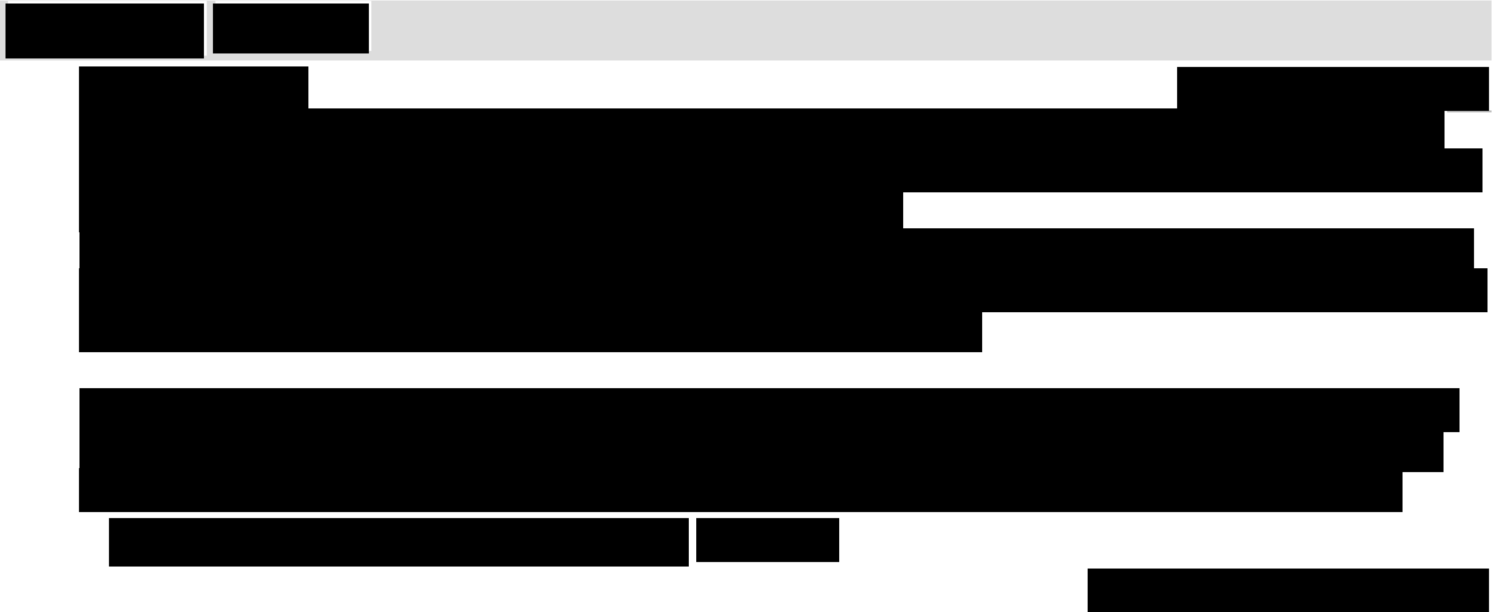
Starting 09/10/2024, the Executive Director and Sales Director conduct weekly audits of all areas of the home to ensure sanitation is maintained.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (- 12/19/2024)



Withdrawn **3/7/25**



95 - Furniture and Equipment

16. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 9/4/2024, the front panel of the sink was missing and exposing a rough caulked surface in the bathroom of room 320.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/04/2024 the Executive Director took immediate action to correct the violation by Pennsylvania Bureau of Human Service Licensing. The repair to the front panel was performed by the Director of Environmental Services prior to re-entry of residents.
On 09/04/2024, all suites were inspected to ensure all furniture and equipment was in good repair, clean and free of hazards.
Inspections are conducted on a daily basis throughout the community by all staff to ensure all furniture and equipment are in good repair, clean, and free of hazards.

Starting 09/10/2024, the Executive Director and Sales Director conduct weekly audits of all areas of the home to ensure compliance is maintained. The Executive Director in conjunction with the Director of Environmental Services conducts a daily check of all common areas to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (- 02/04/2025)

141a 1-10 Medical Evaluation Information

18. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 1's medical evaluation has no completion date, but was evaluated on [redacted], did not indicate cognitive function. The section was left blank.

Plan of Correction ***Accept ([redacted] - 10/17/2024)***

On 09/05/2024 The Executive Director and Director of Health and Wellness took immediate action to implement to address the violation of code 141a 1-10 Medication of Evaluation Information. The Director of Health and Wellness will audit each form and verify all residents have received all evaluations in accordance with requirements by the Pennsylvania Bureau of Human Service Licensing. These audits will be ongoing and indefinite.

On 09/27/2024 an in-service was conducted by the Executive Director with the Director of Health and Wellness. The in-service was to discuss Medical Evalution Information, and the auditing of forms associated. Moving forward, and additional audit of the medical evaluation form, will be conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented ([redacted] - 12/19/2024)

183e - Storing Medications

19. 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 8/27/2024 resident 3's Levemir Flex pen, opened 7/1/2024, was observed in the medication cart at the temporary emergency relocation site. According to the manufacturer's instructions it should be discarded after 42 days.

Resident 4 is prescribed Lorazepam tab .5mg. The blister pack was observed with the foil punctured on pill 20, however the pill was still in blister pack.

183e - Storing Medications (continued)

Resident 5 is prescribed Lorazepam tab .5mg. The blister pack was observed with the foil punctured on pill 13, however the pill was still in blister pack.

Plan of Correction ***Accept (- 10/17/2024)***

On 08/272024 the Executive Director took immediate action to address the violation of code 183e. An immediate cart audit was performed by the charge nurse, at the instruction of the Director of Health and Wellness.

On 09/09/2024 the Executive Director and Director of Health and Wellness implemented new procedures addressing issues which were noticed as deficiencies while displaced at the temporary location.

Starting 09/10/2024 all medications carts will be audited bi-weekly to ensure all medications prescribed to residents are available to be administered in conjunction with the physician's instructions. All medications are to be stored on the secured medication cart, and the cart will be kept secure at all times. There will be various shift checks conducted by the charge nurse, The Director of Health and Wellness, and The Executive Director. Daily checks of all MAR's will be conducted by the Director of Health and Wellness. On 09/11/2024 a medication administration refresher was conducted to all medication administration staff. This training was conducted to inform the staff of new procedures for safe storage and access, security, distribution and use of medications and medical equipment. These audits, checks and trainings will be ongoing and indefinite.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (- 12/19/2024)

185a - Implement Storage Procedures

20. 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 6 is prescribed nystatin powder apply twice daily as needed for rash.
On 8/27/2024 this medication was not available at the temporary emergency relocation site.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/09/2024 the Executive Director and Director of Health and Wellness implemented new procedures addressing issues which were noticed as deficiencies while displaced at the temporary location.
All medications carts will audited bi-weekly to ensure all medications prescribed to residents are available to be administered in conjunction with the physician's instructions. All medications are to be stored on the secured medication cart, and the cart will be kept secure at all times. There will be various shift checks conducted by the charge nurse, The Director of Health and Wellness, and The Executive Director. Daily checks of all MAR's will be conducted by the Director of Health and Wellness. On 09/11/2024 a medication administration refresher was conducted to all medication administration staff. This training was conducted to inform the staff of new procedures for safe storage and access, security, distribution and use of medications and medical equipment. The staff was

185a - Implement Storage Procedures (continued)

informed the start date for these audits began on 09/10/2024. These audits, checks and trainings will be ongoing and indefinite.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (█ - 12/19/2024)

187a - Medication Record

21. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 7 is prescribed Lorazepam tab 0.5 mg as needed every 8 hours for anxiety. The narcotic log indicates the resident received this medication 8/19/2024 at 2 PM and 8/21/2024 at 5 PM. However, resident’s 8/2024 medication administration record does not indicate name and initials of the staff person administering the medication on these days.

Plan of Correction ***Accept (█ - 10/17/2024)***

On 09/09/2024 the Executive Director and Director of Health and Wellness implemented new procedures addressing issues which were noticed as deficiencies while displaced at the temporary location.
All medications carts will be audited bi-weekly to ensure all medications prescribed to residents are available to be administered in conjunction with the physician's instructions. All medications are to be stored on the secured medication cart, and the cart will be kept secure at all times. There will be various shift checks conducted by the charge nurse, The Director of Health and Wellness, and The Executive Director. Daily checks of all MAR's will be conducted by the Director of Health and Wellness. On 09/11/2024 a medication administration refresher was conducted to all medication administration staff. This training was conducted to inform the staff of new procedures for safe storage and access, security, distribution and use of medications and medical equipment. The staff was informed the start date for these audits began on 09/10/2024. These audits, checks and trainings will be ongoing and indefinite.

Licensee's Proposed Overall Completion Date: *10/13/2024*

187a - Medication Record *(continued)*

Not Implemented (- 02/14/2025)

187b - Date/Time of Medication Admin.

22. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 8/27/2024 during breakfast med pass at the temporary emergency relocation site, resident 6 was administered lorazepam tablet .5mg take once daily. Staff person B did not initial or record the date and time of administration until 8/27/2024 at 1:22 PM when a medication audit was being conducted by an agent of the Department.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/09/2024 the Executive Director and Director of Health and Wellness implemented new procedures addressing issues which were noticed as deficiencies while displaced at the temporary location.
All medications carts will be audited bi-weekly to ensure all medications prescribed to residents are available to be administered in conjunction with the physician's instructions. All medications are to be stored on the secured medication cart, and the cart will be kept secure at all times. There will be various shift checks conducted by the charge nurse, The Director of Health and Wellness, and The Executive Director. Daily checks of all MAR's will be conducted by the Director of Health and Wellness. On 09/11/2024 a medication administration refresher was conducted to all medication administration staff. This training was conducted to inform the staff of new procedures for safe storage and access, security, distribution and use of medications and medical equipment. The staff was informed the start date for these audits began on 09/10/2024. These audits, checks and trainings will be ongoing and indefinite.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (- 02/14/2025)

187d - Follow Prescriber's Orders

23. Requirements

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

Description of Violation

Resident 6 is prescribed Atorvastatin tablet 80mg at bedtime. However, resident 7 was not administered this medication on 8/26/2024 and the medication administration record does not reflect the reason why.

Resident 8 is prescribed Melatonin 3mg tablet at bedtime. However, resident 8 was not administered this medication on 8/21/2024 and the medication administration record does not reflect the reason why.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/09/2024 the Executive Director and Director of Health and Wellness implemented new procedures

187d - Follow Prescriber's Orders (continued)

addressing issues which were noticed as deficiencies while displaced at the temporary location.
All medications carts will audited bi-weekly to ensure all medications prescribed to residents are available to be administered in conjunction with the physician's instructions. All medications are to be stored on the secured medication cart, and the cart will be kept secure at all times. There will be various shift checks conducted by the charge nurse, The Director of Health and Wellness, and The Executive Director. Daily checks of all MAR's will be conducted by the Director of Health and Wellness. On 09/11/2024 a medication administration refresher was conducted to all medication administration staff. This training was conducted to inform the staff of new procedures for safe storage and access, security, distribution and use of medications and medical equipment. The staff was informed the start date for these audits began on 09/10/2024. These audits, checks and trainings will be ongoing and indefinite.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Not Implemented (- 02/14/2025)

190a - Completion Medication Course

24. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department’s performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration course, administered breakfast medications to residents 2, 3 and 7 on 8/27/24.
On 8/27/2024 at breakfast medication pass, resident 2 received amlodipine tablet 2.5 mg
On 8/27/2024 at breakfast medication pass, resident 3 received Levothyroxine tablet 100MCG
On 8/27/2024 at breakfast medication pass, resident 7 received Carb/Levo ER tablet 50-200mg

Plan of Correction ***Accept (- 10/17/2024)***

On 09/04/2024 The Executive took immediate action in response to the violation by the Pennsylvania Bureau of Human Service Licensing.
Staff person B was removed from all medication application assignments, until such time as has successfully the Department - approved medications administration course.

All medication administration staff is required to complete the state approved medication administration course and pass the state certification exam. On 10/01/2024 Artis Senior Living of Huntingdon Valley enrolled our community's charge nurse in the state approved Train-the Trainer program. Until completion by our staff member, all training of medication administration personnel will be conducted by a state approved trainer. All post completion requirements will be monitored by the Director of Health and Wellness.

On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director. Monthly audits of staff files for completed required staff trainings will be conducted by the Executive Director.

190a - Completion Medication Course *(continued)*

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (- 02/04/2025)

190b - Insulin Injections

25. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 8/27/2024 at breakfast and lunch medication passes, staff person B, who has not successfully completed the Department-approved medications administration course and has not successfully completed a Department-approved diabetes patient education program within the last 12 months , administered insulin to resident 3.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/04/2024 The Executive took immediate action in response to the violation by the Pennsylvania Bureau of Human Service Licensing.
Staff person B was removed from all medication application assignments, until such time as has successfully the Department - approved medications administration course. The staff member must also complete a Department approved diabetes patient education program.

Starting 01/2025 bi-annual Diabetic Education will be conducted for all staff members administered diabetic medications. The training will be conducted by a state approved diabetic medication administration trainer.
Starting 09/30/2024 all medications administration staff files will be audited monthly by the Executive Director to avoid a staff member being out of compliance in between the bi-annual training. Compliance and med training compliance audits are conducted by the Director of Business Services.

On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director.
Monthly audits of staff files for completed required staff trainings will be conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (- 02/04/2025)

233c - Key-Locking Devices

26. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices *(continued)*

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near either gate to exit outside area of the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept (- 10/17/2024)***

On 09/04/2024 the Executive Director took immediate action to address the violation of code 233c-Key Locking Devices.

Directions for operating the home's locking mechanism was conspicuously posted near the gate to exit the outside area of the Secure Dementia Care Unit, by the Director of Environmental Services.

Starting 09/05/2024 weekly monitoring of all conspicuously posted in and about the community will be conducted by the Director of Environmental Services, and by the Executive Director. This monitoring will ongoing and indefinite.

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented (- 02/04/2025)

236 - Staff Training

27. 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 B, who works in the Secure Dementia Care Unit (SDCU) had no hours of training in dementia care during the 1/1/2023 to 12/31/2023 training year.

Plan of Correction ***Accept (- 10/17/2024)***

On 09/06/2024 Staff person B completed the Pennsylvania Direct Care Certification. On 09/10/2024 staff person B received the required 6 hours of dementia specific training.

The Executive Director has taken immediate action to implement a plan to ensure all care staff persons have at least 12 hours of annual training relating to their job. There will be 3 opportunities per month provided via either, professional partners, paid service providers, or Artis professionals. The requirement is that each employee attend at least one of the provided sessions. There will be quarterly sessions for the 6-hour dementia care training. All staff members will be required to attend at least one of the offered sessions, to completion. The training will be conducted by The Executive Director, The Director of Health and Wellness, The Director of Business Services, The Director of Sales and Marketing, The Director of Culinary Services, The Director of Environmental Services, The Director of Lifestyle Enrichment and The Director of the Artis Way.
On 09/16/2024 thru 09/17/2024 The Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Regional Director of Business Services. The Director of Business Services will continue to receive monthly in-services conducted by the Executive Director. Monthly audits of staff files for completed required staff trainings will be conducted by the Executive Director.

236 - Staff Training *(continued)*

Licensee's Proposed Overall Completion Date: *10/13/2024*

Implemented ([redacted] - 02/04/2025)

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

Facility Information

Name: *ARTIS SENIOR LIVING OF HUNTINGDON VALLEY* **License #**: *14279* **License Expiration**: *07/18/2025*

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:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/13/2016* **Issued By**: *Township of Lower Moreland*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/04/2024*

Inspection Dates and Department Representative

11/04/2024 - On-Site:

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: *18*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *57* **Have Physical Disability**: *0*

Inspections / Reviews

11/04/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/12/2024*

Inspections / Reviews *(continued)*

12/20/2024 - POC Submission

Submitted By: [redacted]

Date Submitted: *12/13/2024*

Reviewer: [redacted]

Follow-Up Type: *POC Submission*

Follow-Up Date: *12/24/2024*

02/10/2025 - POC Submission

Submitted By: [redacted]

Date Submitted: *12/24/2024*

Reviewer: [redacted]

Follow-Up Type: *Bypass Document Submission*

02/14/2025 - Bypass Document Submission

Submitted By: [redacted]

Date Submitted: *02/10/2025*

Reviewer: [redacted]

Follow-Up Type: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 11/04/2024, at the entrance conference at 9:00 a.m., an agent of the Department requested access to the list of refunds for discharge and death residents and the eight hospice agency certificates. Staff person A did not provide the information during the time of the inspection.

Plan of Correction ***Accept (█ - 12/20/2024)***

Subsequent to the violation on 11/04/2024 it was learned that the refunds for discharge and death residents are maintained in a database by the Business Office Manager. Moving forward a binder will be maintained in the Executive Director's office, and will be reconciled, by the Executive Director monthly, starting immediately.

The hospice agencies were contacted and asked to provide and updated agency certificates and documentation. This too will be maintained in a binder and kept, for presentation, in the office of the Executive Director. starting immediatel.

Proposed Overall Completion Date: 12/13/2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (█ - 02/11/2025)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident’s designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident’s power of attorney for health care or health care proxy or a resident’s designated person, or if a court orders disclosure.

Description of Violation

A therapeutic diet list containing resident dietary information was displayed in the hallway on November 4, 2024. This was found in the glass cabinet for postings at the 100 neighborhood hall.

Plan of Correction ***Accept (█ - 12/20/2024)***

In response to the violation on 11/04/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken by the Executive Director, and on 11/05/2024 the dietary information was amended to protect the confidentially of residents on the list. All culinary staff was made aware of this mistake. The need of confidentially will be emphasized in all orientations, and the annual Resident's Rights training. The annual Resident's Right's Training will be conducted by the Executive Director.

17 - Record Confidentiality *(continued)*

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (- 02/11/2025)

62 - Contact List

3. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person the administrator, did not maintain a current list of the names, addresses, and telephone numbers of staff persons, including staff person C, hired on .

Plan of Correction ***Accept (- 12/20/2024)***

Subsequent to the violation on 11/04/2024 it was learned that the current list of names are maintained in a database by the Business Office Manager. This database will continue to be maintained and ready for presentation. A separate list of all substitute personnel is also maintained. Should the need arise, a list of all volunteers will be maintained in the business office, though we have not currently instituted a volunteer program, within the community.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (- 02/11/2025)

65a - FS Orientation 1st Day

4. 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 , 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 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.*

65a - FS Orientation 1st Day (continued)

- *Smoke detectors and fire alarms.*
- *Telephone use and notification of emergency services.*

Plan of Correction ***Accept (- 12/20/2024)***

On 11/05/2024 immediate action was taken by the Executive Director to enforce the Artis Senior Living of Huntingdon Valley orientation protocol, for staff D. Orientation is conducted as a joint effort between The Executive Director,
The Director of Health and Wellness to ensure staff D received the required training, The Director of Business Services, The Director of Sales and Marketing, The
Director of Culinary Services, The Director of Environmental Services, The Director of Lifestyle Enrichment and The Director of the Artis Way.
Orientation includes but is not limited to 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 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, and telephone use and notification of emergency services.
An audit of all employee files was conducted to ensure all current staff had received orientation and that orientation addressed the required topics. Implementation of orientation protocols will be ongoing and indefinite

Proposed Overall Completion Date: 12/13/2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/11/2025)

65b - Rights/Abuse 40 Hours

5. 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 (- 12/20/2024)***

On 11/05/2024 immediate action was taken by the Executive Director to enforce the Artis Senior Living of Huntingdon Valley orientation protocol for Staff D. Orientation is conducted as a joint effort between The Executive Director,
The Director of Health and Wellness, The Director of Business Services, The Director of Sales and Marketing, The Director of Culinary Services, The Director of Environmental Services, The Director of Lifestyle Enrichment and The Director of the Artis Way.
Orientation includes but is not limited to 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), and reporting of reportable incidents and conditions. 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 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, and telephone use and notification of emergency services.
Within 24 hours of the conclusion of orientation, an audit of all files of direct care staff persons, ancillary staff persons, substitute personnel and volunteers, completing orientation will be conducted by the Executive Director. The audit will be to confirm the orientee completed 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), and reporting of reportable incidents and conditions.

Proposed Overall Completion Date: 12/13/2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/11/2025)

66a - Staff Training Plan

6. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2024.

Plan of Correction ***Accept (- 12/20/2024)***

On 11/05/2024 immediate action was taken by the Executive Director to enforce the Artis Senior Living of Huntingdon Valley staff training protocol by the development of a staff training plan. Staff training is conducted as a joint effort between The Executive Director,
The Director of Health and Wellness, The Director of Business Services, The Director of Sales and Marketing, The Director of Culinary Services, The Director of Environmental Services, The Director of Lifestyle Enrichment and The Director of the Artis Way.
Orientation includes but is not limited to 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), and reporting of reportable incidents and conditions. 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 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

66a - Staff Training Plan (continued)

fire extinguishers, smoke detectors and fire alarms, and telephone use and notification of emergency services. Within 24 hours of the conclusion of orientation, an audit of all files of direct care staff persons, ancillary staff persons, substitute personnel and volunteers, completing orientation will be conducted by the Executive Director. The audit will be to confirm the orientee completed 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), and reporting of reportable incidents and conditions.

Proposed Overall Completion Date: 12/13/2024

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (- 02/11/2025)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/04/2024, there was a trash bag containing trash on top of a medication cart.

Plan of Correction ***Accept (- 12/20/2024)***

On 11/04/2024 immediate action was taken by the Executive Director. The trash bag was immediately removed the medication cart, the blue towel was immediately removed from resident 1's bedroom, and the blanket was immediately replaced in resident 2's bedroom.

On 11/05/2024 all staff members were immediately re-educated on the importance of maintaining sanitary conditions.
On 11/08/2024 additional training for rendered to all care staff as to code 85a by the Director of Health and Wellness. Training will be provided annually as a reminder of the importance of maintaining sanitary conditions in the care home. This training will be ongoing and indefinite.
Starting 11/11/2024, the Executive Director and Sales Director conduct weekly audits of all areas of the home to ensure sanitation is maintained.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/11/2025)

91 - Telephone Numbers

8. Requirements

2600.

91 - Telephone Numbers *(continued)*

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident 3 bedroom. There was a dial tone on the phone.

Plan of Correction ***Accept (- 12/20/2024)***

On 11/05/2024 immediate action was taken by the Director of Enviornmental Services to place emergency numbers in resident 3's bedroom. These numbers include the nearest hospital and fire department. This will be the practice followed when the community is made aware a working telephone will be placed in bedroom and any resident.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (- 02/11/2025)

Withdrawn ***3/7/25***

Not Implemented (- 02/11/2025)

102e - Privacy - Doors/Partitions

10. Requirements

2600.
102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

Description of Violation

There is no shower curtain in the bathroom of resident 1, which does not afford privacy while in use.

102e - Privacy - Doors/Partitions (continued)

Plan of Correction ***Accept (█ - 12/20/2024)***

On 11/05/2024 the Executive Director took immediate action to correct the violation by Pennsylvania Bureau of Human Service Licensing. A shower curtain was placed on the shower rod in resident 1's bathroom shower, by the Director of Environmental Services.

On 11/11/2024, all suites were inspected to ensure toilets, showers and bathtubs are afforded the necessary privacy.

Inspections are conducted on a daily basis throughout the community by all staff to ensure all furniture and equipment are in good repair, clean, and free of hazards.
Starting 11/11/2024, the Executive Director and Sales Director conduct weekly audits of all areas of the home to ensure compliance is maintained. The Executive Director in conjunction with the Director of Environmental Services conducts a daily check of all common areas to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/11/2025)

103g - Storing Food

11. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There was an apple pie crumble in the kitchenette fridge of the 100 neighborhood that was opened and unsealed.

REPEAT VIOLATION: 9/11/2023

Plan of Correction ***Accept (█ - 12/20/2024)***

On 11/04/2024 the Executive Director took immediate action. The Director of Health and Wellness secured the apple pie crumble.

On 11/05/2024 all staff were trained on the importance of food safety and the violation of 103g. Food safety training will be conducted bi-annually by the Director of Culinary Services. This training will be ongoing and indefinite.
In addition, starting 11/08/2024 daily neighborhood audits are conducted by the Director of Health and Wellness, Charge Nurse and Medication Technicians. In addition, weekly food storage area audits are conducted by the Director of Culinary Services.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/11/2025)

107d - Procedure Emergency Management Agency Submission

12. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

107d - Procedure Emergency Management Agency Submission *(continued)*

Description of Violation

The home's written emergency procedures have not been submitted to the Emergency Management Agency.

Plan of Correction ***Accept (- 12/20/2024)***

On 11/05/2024 the Executive Director took immediate action. The home's written emergency procedures were submitted to the local emergency management agency. Moving forward these procedures will be submitted to the local emergency management agency, on the first day after January 1st of each year, by the Executive Director.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented (- 02/11/2025)

124 - Notice to Fire Department

13. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home,

location of the bedrooms, and the assistance needed to evacuate in an emergency.

Repeat Violation: 9/11/2023

Plan of Correction ***Accept (- 12/20/2024)***

On 12/12/2024 the Executive Director took action. The home notified the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. This information will be submitted, on the first day after January 1st, by the Executive Director moving forward.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (- 02/11/2025)

132d - Evacuation

15. Requirements

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

During the fire drill on July 1st, 2024, at 7:40 p.m., the fire drill lasted 20 minutes. The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert.

Plan of Correction ***Accept (- 12/30/2024)***

(Fire Marshall Township of Lower Moreland, PA) will provide verification of the extended

132d - Evacuation (continued)

emergency evacuation plan on 01/02/2025.

Beginning 09/05/2024, fire drills are reviewed monthly by the Director of Enviornmental Services and Executive Director maintain compliance with the regulation. Fire Drills are conducted monthly.

Licensee's Proposed Overall Completion Date: *12/24/2024*

Not Implemented (█ - 02/11/2025)

162c - Menus Posted

16. 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 the week of 11/03/2024 to 11/09/2024 was not posted in a public and conspicuous place throughout the home. However, the daily menu posted was from September 14, 2024.

Plan of Correction ***Accept (█ - 12/20/2024)***

On 11/05/2024, the Executive Director took immediate action to address this violation by the Pennsylvania Bureau of Human Service Licensing. The home;s menu for the week of 11/03/2024 to 11/09/2024 was placed in the display cabinet of all 4 neighborhoods, by the cook, and verified by the Executive Director. Moving forward an audit of display cabinets of all Neighborhood will be conducted by the Executive Director & Memory Care Director.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/11/2025)

183e - Storing Medications

17. 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

Lorazepam 0.5 mg is prescribed for resident 4. However, the blister pack has an opening on the back of the foil on pill #24. According to the manufacturer's instructions, prescription medications, OTC medications, and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light.

Clonazepam 0.5 mg is prescribed for resident 5. However, the blister pack has an opening on the back of the foil on pill #21. According to the manufacturer's instructions, prescription medications, OTC medications, and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light.

183e - Storing Medications (continued)

Plan of Correction ***Accept (█ - 12/30/2024)***

On 11/05/2024 immediate action was taken by the Executive Director and Director of Health and Wellness. On 11/05/2024, the pharmacy providing blister packs was contacted by the Director of Health and Wellness, and made aware of the issue with opening to stored blister packs. A new, reinforced blister back was designed and will be the blister pack used moving forward. These blister packs are designed to prevent this issue. On 11/05/2024 & 11/06/2024 the Director of Health and Wellness conducted training to help staff with cart management and avoiding blister packs being inadvertently opened.

Licensee's Proposed Overall Completion Date: *12/24/2024*

Not Implemented (█ - 02/11/2025)

185a - Implement Storage Procedures

18. 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 11/04/2024, there was one loose syringe in the locked narcotics box in the 300 neighborhood medication cart.

Resident 6 is prescribed Lorazepam Tab 0.5 mg; the count on the book was 21, but there was only 20 on the blister pack.

Resident 7 is prescribed Lorazepam Tab 0.5 mg; the count on the book was 19, but there was only 18 on the blister pack.

Plan of Correction ***Accept (█ - 12/20/2024)***

Starting 11/08/2024 all medications carts will be audited bi-weekly to ensure all medications prescribed to residents are available to be administered in conjunction with the physician's instructions. All medications are to be stored on the secured medication cart, and the cart will be kept secure at all times. There will be various shift checks conducted by the charge nurse, The Director of Health and Wellness, and The Executive Director. Daily checks of all MAR's will be conducted by the Director of Health and Wellness. On 11/08/2024 a medication administration refresher was conducted to all medication administration staff. This training was conducted to inform the staff of new procedures for safe storage and access, security, distribution and use of medications and medical equipment. These audits, checks and trainings will be ongoing and indefinite.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Not Implemented (█ - 02/11/2025)

225c - Additional Assessment

20. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

225c - Additional Assessment *(continued)*

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 9's current assessment was completed on [redacted]. However, the resident's previous assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 12/20/2024)***

From 11/05/2024 thru 11/10/2024 all resident assessments were audited by the Director of Health and Wellness and the Charge Nurse to ensure all annual assessments were in line with state requirements. The Director of Health and Wellness maintains a database of assessments using the VITALS system. Regular audits of all resident's assessments (coming due) are conducted daily by the Director of Health and Wellness and the Charge Nurse. This practice will continue indefinitely. All assessments are current and properly signed.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented ([redacted] - 02/11/2025)

227g -Support Plan Signatures

21. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Staff member A participated in the development of resident 9's support plan on [redacted]. However, staff member A did not sign the support plan.

REPEAT VIOLATION: 9/11/2023

Plan of Correction ***Accept ([redacted] - 12/20/2024)***

From 11/05/2024 thru 11/10/2024 all resident support plans were audited by the Director of Health and Wellness and the Charge Nurse to ensure all annual assessments were in line with state requirements. The Director of Health and Wellness maintains a database of support plans using the VITALS system. Regular audits of all resident's support plans are conducted daily by the Director of Health and Wellness and the Charge Nurse. This practice will continue indefinitely. All resident support plans are current and properly signed.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Implemented ([redacted] - 02/11/2025)