

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

December 10, 2024

[REDACTED]
ARTIS SENIOR LIVING OF LEMOYNE LLC
[REDACTED]

RE: ARTIS SENIOR LIVING OF WEST
SHORE
150 NORTH 12TH STREET
LEMOYNE, PA, 17043
LICENSE/COC#: 33370

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/30/2024 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 WEST SHORE **License #:** 33370 **License Expiration:** 12/01/2024
Address: 150 NORTH 12TH STREET, LEMOYNE, PA 17043
County: CUMBERLAND **Region:** CENTRAL

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: ARTIS SENIOR LIVING OF LEMOYNE LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-1 **Date:** 10/04/2017 **Issued By:** Borough of Lemoyne

Staffing Hours

Resident Support Staff: **Total Daily Staff:** 128 **Waking Staff:** 96

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Incident **Exit Conference Date:** 10/30/2024

Inspection Dates and Department Representative

10/30/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 64 **Residents Served:** 64

Secured Dementia Care Unit

In Home: Yes **Area:** Artis Senior Living **Capacity:** 64 **Residents Served:** 64

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 63
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 64 **Have Physical Disability:** 0

Inspections / Reviews

10/30/2024 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/14/2024

11/08/2024 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 12/09/2024
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/15/2024

Inspections / Reviews *(continued)*

11/12/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/09/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/17/2024

12/10/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/09/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

42b - Abuse

1. 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] at approximately 12:25PM, Resident [redacted] was yelling vulgar comments to Resident [redacted]. Resident [redacted] became upset and pushed Resident [redacted]. This caused Resident [redacted] lost [redacted] balance and fall. As a result of the incident, Resident [redacted] sustained a small bruise to the head.

On [redacted] at approximately 8:15PM, Resident [redacted] grabbed Resident [redacted] by the shirt. Resident [redacted] yelled at Resident [redacted] to stop, and Resident [redacted] did. As Resident [redacted] walked away, Resident [redacted] grabbed Resident [redacted] again and proceeded to push Resident [redacted] head against a wall. Staff intervened and Resident [redacted] stopped. As a result of the incident, Resident [redacted] sustained a lump to the right side of [redacted] head near the ear.

On [redacted] 4 at approximately 6:45PM, Resident [redacted] and Resident [redacted] were arguing in the community center. Resident [redacted] hit Resident [redacted] on the arm. Staff attempted to intervene; however, the argument escalated and Resident [redacted] grabbed Resident [redacted] by the arm and pushed Resident [redacted] to the ground. As a result of the incident, Resident [redacted] sustained left shoulder and hip pain and was taken to the ER.

Repeated Violation - 07/09/2024, et al

Plan of Correction

Accept ([redacted] 11/12/2024)

Staff members intervened in all listed cases, and no further harm came to any resident. Residents were monitored hourly by care-partners for 72 hours. Residents were monitored for any further interactions following the incident, and no further altercations occurred.

At the communities request, Resident [redacted] has been receiving in patient psych services since [redacted]. Resident will be reevaluated upon return to the community.

Staff members were alerted to the behaviors via the communities 24 hour report and routine shift huddles.

Resident support plans were updated by Health and wellness director to reflect the behaviors.

All staff education regarding abuse and abuse reporting was conducted 11/7/2024 by executive director and director of health and wellness. Additional training will be conducted on 11/26.

Director of health and wellness or designee will conduct monthly education sessions on starting on 11/7/204 for all care staff members for a period of three months regarding monitoring residents and de-escalation techniques.

Proposed Overall Completion Date: 02/07/2025

Licensee's Proposed Overall Completion Date: 12/15/2024

Implemented ([redacted] - 12/10/2024)