pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ARTIS SENIOR LIVING OF BETHEL PARK LLC**
LEGAL ENTITY

To operate **ARTIS SENIOR LIVING OF SOUTH HILLS**
NAME OF FACILITY OR AGENCY

Located at **1001 HIGBEE DRIVE, BETHEL PARK, PA 15102**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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 **June 10, 2025** until **June 10, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **449160**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: June 10, 2025

[redacted]
Artis Senior Living of Bethel Park LLC
[redacted]

RE: Artis Senior Living of South Hills
1001 Higbee Drive
Bethel Park, PA 15102
License # 44916

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on February 11, 2025, February 12, 2025, and April 24, 2025, and the corrections you have made after our inspections, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ARTIS SENIOR LIVING OF SOUTH HILLS* **License #:** *44916* **License Expiration:** *05/21/2025*

Address: *1001 HIGBEE DRIVE, BETHEL PARK, PA 15102*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name [redacted]

Legal Entity

Name: *ARTIS SENIOR LIVING OF BETHEL PARK LLC*

Addres [redacted]

Phone:

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *130* **Waking Staff:** *98*

Inspection Information

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

Reason: *Renewal, Provisional, Incident* **Exit Conference Date:** *02/12/2025*

Inspection Dates and Department Representative

02/11/2025 - On-Site: [redacted]

02/12/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served:** *65*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire home* **Capacity:** *72* **Residents Served:** *65*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *65*

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

Have Mobility Need: *65* **Have Physical Disability:** *1*

Inspections / Reviews

02/11/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/23/2025*

03/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/23/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/31/2025*

04/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/23/2025*

05/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2025*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

65e - 12 Hours Annual Training

1. 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.

Description of Violation

Direct care staff person A, hired [redacted]22, only completed 1 of the 12 hours of annual training documented for training hours during the July 1, 2023 to June 30, 2024 staff training year.

Direct care staff person B, [redacted]hired [redacted]/22, did not complete any of 12 the hours of annual training documented for the July 1, 2023 to June 30, 2024 staff training year.

Plan of Correction ***Accept [redacted] 04/15/2025)***

The Director of Community Integration (DCI), completed a full audit on March 27, 2025 of all current staff persons training records during the 2023/2024 training year to identify all associates that do not have the 12 hours of mandatory annual training. See attachment for documentation.

All associates, except for those hired after July 1, 2024 will be required to attend a 2 day 12 hour training. Direct care staff will attend an additional day to receive 6 hours of dementia training.

The dates of the 18 hour (3 day training training):

- *Week of April 7th*
- *Week of April 14th*
- *Week of April 22nd*
- *Week of April 29th*

The Executive Director re-educated The Director of Community Integration on Monday, March 31, 2025 of regulation 65e. Documentation of education shall be kept in accordance with 260.65i.

To ensure ongoing compliance with regulation 65e, a new mandatory training sign off sheet has been created to ensure that all associates are receiving their 12 hours of annual training. Ongoing monitoring / auditing of the form will be completed by the Executive Director and Director of Community Integration. See attached document.

Licensee's Proposed Overall Completion Date: *04/07/2025*

Implemented [redacted] 05/20/2025)

65i - Training Record

2. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

There were numerous training documentation sheets for the July 1, 2023 – June 30, 2024 staff training year that did not include required items as follows:

65i - Training Record (continued)

**5/15/24 training record course titled "July All Associate meeting" on Fire Safety, Emergency Preparedness, Active Shooter, Missing Person, and Elopement does not include: Content of Course, Training Source, Location, Length (# of hours completed) these sections are blank on the form.*
**5/15/24 training record for course titled "August All Associate Meeting" on Dignity and Respect, Resident Rights, does not include: Content of Course, Training Source, Location, Length (# of hours completed) these sections are blank on the form.*
**6/20/24 training record for course titled "August All Associate Meeting" does not include Content of Course, Training Source, Location, Length (# of hours completed) these sections are blank on the form.*
**6/4/24 training record for course titled "August 2023 All Associate Meeting" does not include Content of Course, Training Source, Location, Length (# of hours completed) these sections are blank on the form.*

The following training documentation dated 5/15/24 for direct care staff person A, hired [redacted]22, were missing numerous items to include Content of Course, Training Source, Location, Length (# of hours completed) for the following topics:
**Assisting with Care Customer Service*
**Fire Safety; Emergency Preparedness; Active Shooter; Missing person elopement*
**Dignity and Respect; Resident Rights*
**Locking Poisons; Abuse; Communication + dementia practical approaches for residents with dementia*
**Falls and accident prevention; Creating a safe environment for residents with dementia*
**Connecting with families and dementia; what is ADLs and IADLs*
**Care for residents with dementia; when a resident resists care*
**If physical aggression occurs; care for resident with dementia/mental illness*

Plan of Correction ***Accept[redacted] 04/15/2025)***

Records for the 2023/2024 training year did not specify DHS requirements and will be correctly documented moving forward.

The Director of Community Integration (DCI), completed a full audit on Monday, March 31, 2025 of all current staff persons training records during the 2023/2024 training year and the current training year to identify if all the training records include date, source, content, length and any copies of any certificates received.

All associates, except for those hired after July 1, 2024 will be required to attend a 2 day 12 hour training. Direct care staff will attend an additional day to receive 6 hours of dementia training.

The dates of the 18 hour (3 day training training):
Week of April 17th
Week of April 14th
Week of April 22nd
Week of April 29th

The Executive Director re-educated The Director of Community Integration on Monday, March 31, 2025 of regulation 65i. Documentation of education shall be kept in accordance with 260.65i.

To ensure ongoing compliance with regulation 65i, a new mandatory training sign off sheet has been created to ensure that all training records include date, source, content, and length of each course. Ongoing monitoring /

65i - Training Record (continued)

auditing of the form will be completed by the Executive Director and Director of Community Integration. See attached document.

Training records will be monitored at our monthly Quality Management review meeting.

Licensee's Proposed Overall Completion Date: *04/07/2025*

Implemented [redacted] - 05/20/2025)

84 - Heat Sources

3. Requirements

2600.
84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

Description of Violation

On 2/11/25 at 10:47 a.m., the top cross bar on the frame of the fireplace screen in Forbes Field living room measured in excess of 238 degrees Fahrenheit.

On 2/11/25 at approximately 11:10 a.m., the top cross bar on the frame of the fireplace screen in Kennywood living room measured 136 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] 04/15/2025)***

In response to the violation on 02/11/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/11/2025 by the Director of Environmental Services to turn off the fireplaces on Forbes, Kennywood, Hardwood Acres and Kaufmanns and the gas was shut off making them inoperable.

On 04/01/2025 Seans Electrical Services removed all four wall switches and replacing them with blank plates. Attached is the proposal which shows that the work was performed at 8 AM on 4/1/2025 along with a photo of the switch that will be removed from the wall and the new plate that was installed. This will further ensure that the fireplaces remain inoperable on all four neighborhoods in the community.

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented ([redacted] - 05/20/2025)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

According to staff person C, [redacted] on 2/10/25, resident #1's glucometer was used by an agency nurse to measure resident #2's blood glucose level.

Repeat Violation 3/21/23 et al.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept [redacted] 04/15/2025)***

On February 10, 2025 the [redacted] for resident #2 was notified regarding the wrong glucometer being used. The new glucometer for resident #1 was delivered by pharmacy on February 12, 2025. The POA for resident #1 was notified on March 19, 2025 that the glucometer was used on another resident and that it was replaced by pharmacy. The physician for resident #1 and resident #2 was notified notified on February 10, 2025. No new orders were received.

The agency nurse was sent home following the incident that occurred on February 10, 2025 and was added to the Do Not Return list from Clipboard.

Director of Health and Wellness on 3/20/2025 placed all resident glucometers in an individual box which has a label on the top to ensure that the nurse / med tech is using the correct glucometer. See attached photos

The Director of Health and Wellness will re-educate all nurses and med tech's by Friday, March 28, 2025 of regulation 85a, including the importance of using individual glucometers for all accu-chek readings. Documentation of education shall be kept in accordance with 2600.65i.

All Agency Associates beginning with the NOC Shift on 4/3/2025 will sign off on an acknowledgement sheet regarding the expectations for blood sugar checks. See attachment for documentation.

Diabetic Training has been scheduled for March 31st at 2:00 PM with [redacted] who is our Diabetic Educator. This training will be conducted virtually and will be required for all Med Techs and Nurses. The training will be recorded and will need to be viewed by all nurses and med techs by Friday, April 4, 2025. Documentation of education shall be kept in accordance with 2600.65i.

Beginning the week of March 24, 2025 the Director of Health and Wellness / Designee will perform a weekly audit for 12 weeks to monitor glucose testing and ensure we are following the correct policy and procedures. This will conclude on June 13, 2025. See attachment for audit sheet.

Beginning the week of March 24, 2025 The Director of Health and Wellness / Designee will complete one "Blood Glucose Monitoring Competency Evaluation Form" weekly to ensure that we are following our policy and procedures. This will conclude on June 13, 2025. See attachment for evaluation form.

Licensee's Proposed Overall Completion Date: *04/02/2025*

Implemented [redacted] 05/20/2025)

132c - Fire Drill Records

5. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill completed 2/29/24 at 10:34 does not indicate if it was a.m. or p.m.

132c - Fire Drill Records (continued)

The home's fire drill records did not include each exit route used as follows:
** 1/25/24 at 3:18 p.m. only indicates "away from 115"*
** 2/29/24 at 10:34 only indicates "Away from F-lobby"*

Repeat Violation 3/21/23 et al.

Plan of Correction ***Accept [redacted] - 04/15/2025)***

The fire drill that was completed on 2/29/2024 was at 10:34 AM. Attached is is the Guardian Protection log for 2/29/2024 which shows AM.

Executive Director updated the fire drill log on 4/2/2025 to reflect that the fire drill that occurred on 2/29/2024 was at 10:34 AM. Please see attachment for documentation.

The Executive Director was unable to update the fire drill log to reflect the exit route used for the drills that occurred on 1/25/24 and 2/26/24.

Director of Environmental Services was hired on [redacted]24. The fire drills from March 2024 - December 2024 included the exit route used.

Executive Director re-educated Director of Environmental Services on Thursday, March 20, 2025 of regulation 132c and ensured that we are documenting the exit route used. Fire drill records will specific am or pm which was reviewed during the training that occurred. Documentation of education shall be kept in accordance with 2600.65i. See attachment for documentation.

The Executive Director / Designee will audit the fire drill records monthly to ensure that exit routes are indicated. See attachment for audit sheet.

Proposed Overall Completion Date: 04/14/2025

Licensee's Proposed Overall Completion Date: *04/14/2025*

Implemented [redacted] - 05/20/2025)

132h - Designated Meeting Place

6. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

The fire drill record for 1/25/24 at 3:18 p.m. indicates that only 64 of 65 residents present in the home were evacuated.

The fire drill record for 2/29/24 at 10:34 indicates that only 65 of 66 residents present in the home were evacuated.

132h - Designated Meeting Place *(continued)*

Plan of Correction ***Accept [redacted] 04/15/2025)***

The Director of Environmental Services / Designee will re-educate all associates on regulation 132h by Friday, April 11th. We will ensure that all residents are evacuated during fire drills. Documentation of education shall be kept in accordance with 2600.65i.

The Executive Director / Designee will audit the fire drill records monthly to ensure that all residents were evacuated. See attachment for audit sheet.

Attached is the 2024 letter from [redacted] Fire Inspector that shows Artis Senior Living has an evacuation time of fifteen minutes.

Proposed Overall Completion Date: 04/11/2025

Licensee's Proposed Overall Completion Date: *04/11/2025*

Implemented [redacted] 05/20/2025)

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

On 2/12/25, there was a clear zip top bag containing an insulin pen of Humalog 100unit/1ml with pharmacy label for resident #1 in the Forbes Field medication cart. The pharmacy label indicated Humalog 100unit/1ml – inject SUBQ as directed per sliding scale coverage in the morning and at 4pm. The pharmacy label did not include the sliding scale for coverage.

Resident #3 is ordered Metoprolol tartrate 25mg – give 1 tab by mouth every day for essential primary HTN with parameters to hold if SBP<100, DBP<50, HR<50. However, on 2/12/25, the pharmacy label for this medication did not include the parameters.

Repeat Violation 3/21/23 et al.

Plan of Correction ***Accept [redacted] 04/15/2025)***

Omni Pharmacy was notified by Director of Health and Wellness on 2/14/25 that moving forward all sliding scales will need to be printed on insulin labels.

DHW added change of direction sticker on 2/14/25 to Resident #1 insulin pen of Humalog.
DHW added change of direction sticker on 2/14/25 to Resident #3 Metoprolol tartrate.

The Director of Health and Wellness / Designee will re-educate all nurses and med techs of regulation 184a by March 28, 2025. Documentation of education shall be kept in accordance with 2600.65i.

184a - Resident's Meds Labeled (continued)

The Director of Health and Wellness / Designee will complete initial cart audits by March 28, 2025. Monthly cart audits will be conducted by the Director of Health and Wellness / Designee for April, May and June.

Starting Monday, March 24, 2025, Nurses and Med Techs will complete audits for any medication changes and new medications received for their shift and ensure the medications labels are correct. Audits will last for 90 days and will conclude on June 21, 2025. See attachment for audit sheets.

The Director of Health and Wellness / Designee will review audits weekly to ensure that we are compliance of the regulation. The Director of Health and Wellness / Designee will complete random audits following the completion of the daily sheets that conclude on June 21, 2025.

Licensee's Proposed Overall Completion Date: *04/02/2025*

Implemented [redacted] 5/20/2025)

185a - Implement Storage Procedures

9. 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 2/9/25 at 4:15 p.m., the reading in resident #2's glucometer was 115. However, 119 was entered on the resident's February 2025 medication administration record (MAR) for 4:30 p.m.

Resident #4 is ordered Betamethasone 0.05% cream twice daily as needed for flares. However, on 2/12/25 at 12:00 p.m., this medication was not available in the home.

On 2/3/25 at 8:00 a.m., a blood glucose reading of 189 was entered on resident #1's February 2025 medication administration record (MAR). However, this blood glucose measurement was not in the resident #1's glucometer.

On 2/3/25 at 7:30 a.m., a blood glucose reading of 111 was entered on Resident #2's February MAR. However, this blood glucose measurement was not in resident #2's glucometer.

Repeat Violation 3/21/23 et al.

Plan of Correction ***Accept [redacted] 04/15/2025)***

The medication Betamethasone 0.05% cream for Resident #4 was ordered on 2/12/2025 and was delivered to the community on 2/12/2025.

The [redacted] who entered the blood sugar checks for resident #1 and resident #2 was sent home from [redacted] shift on 2/3/2025 and was added to the Do Not Return list with Clipboard. No adverse effects noted for either resident. The physician for resident #1 and resident #2 was notified on March 19, 2025.

The Director of Health and Wellness / Designee will re-educate all nurses and med techs of regulation 185a by Friday, March 28, 2025. Documentation of education shall be kept in accordance with 2600.65i.

185a - Implement Storage Procedures (continued)

Starting Monday, March 24, 2025, Nurses and Med Techs will complete audits for any new medication orders or medications re-orders to ensure that information was sent to the pharmacy on their shift. Audits will last for 90 days and will conclude on June 21, 2025. See attachment for audit sheet.

To ensure that the blood glucose values are being entered correctly into the MAR we have implemented a 2 step verification process. This process will start on March 24, 2025 and will be monitored for 90 days concluding on June 21, 2025. See attachment for verification form.

All Agency Associates beginning with the NOC Shift on 4/3/2025 will sign off on an acknowledgement sheet regarding the expectations for blood sugar checks. See attachment for documentation.

The Director of Health and Wellness / Designee will review verification logs weekly to ensure the correct information is documented on the logs.

Licensee's Proposed Overall Completion Date: *04/02/2025*

Implemented [redacted] 05/20/2025)

187a - Medication Record

10. Requirements

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

Description of Violation

Resident #1's February 2025 medication administration record (MAR) entry does not include a diagnosis or purpose for Zituvio 100mg – give 1 tab by mouth every day.

Plan of Correction ***Accept[redacted] 04/15/2025)***

On February 18, 2025, Coordinator of Health and Wellness added diagnosis to Resident #1's Zituvio 100mg medication.

The Director of Health and Wellness / Designee will re-educate all nurses and med techs of regulation 187a by March 28, 2025. Documentation of education shall be kept in accordance with 2600.65i.

The Director of Health and Wellness / Designee will complete a full MAR audit by Monday, March 31, 2025 to ensure that all medications include a diagnosis.

Starting Monday, March 24, 2025, Nurses and Med Techs will complete audits for new medication orders received on their shift and ensure that a diagnosis was associated with the medication. Audits will last for 90 days and will conclude on June 21, 2025. See attachment for audit sheets.

Licensee's Proposed Overall Completion Date: *04/02/2025*

Implemented [redacted] 05/20/2025)

231b - Medical Evaluation

11. Requirements

231b - Medical Evaluation *(continued)*

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #5 was admitted to the home on [redacted]4 and has a diagnosis of dementia. However, the resident's initial medical evaluation was not completed until [redacted]/24.

Repeat Violation 3/21/23 et al.

Plan of Correction ***Accept ([redacted]04/15/2025)***

[redacted] Executive Director re-educated [redacted] Director of Health and Wellness and [redacted] Director of Sales and Marketing of this regulation on Thursday, March 20, 2025. Documentation of education shall be kept in accordance with 2600.65i. See attached documentation.

Starting March 24, 2025 all DME's will be reviewed by the Director of Health and Wellness / Designee and the Executive Director / Designee to ensure that all DME's are completed within 60 days prior to admission. The Audit will conclude on September 30, 2025. See attachment for audit sheet.

Licensee's Proposed Overall Completion Date: *04/02/2025*

Implemented [redacted] 05/20/2025)

233c - Key-Locking Devices

12. 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.

Description of Violation

The codes posted near the keypads at the following exits were not distinguishable by the average person:

** Door to exit through the reception lobby.*

** Exit at the end of hall in Forbes Field neighborhood near rooms 114 and 115.*

** Exit door in Kennywood neighborhood near room #229.*

** Exit door at end of Hartwood Acres neighborhood hallway.*

** Exit door in back hall of Kaufmann neighborhood near room #415.*

Plan of Correction ***Accept [redacted]04/15/2025)***

The Director of Community Integration replaced all Exit Door code signs with a distinguishable code on March 19, 2025. Attached is the new picture with the code. The same procedure will continue as codes change in the future.

The Director of Community Integration will complete an audit once a month for 12 months beginning in April to ensure that that all door codes are conspicuously posted at all exits. See attachment for documentation.

Licensee's Proposed Overall Completion Date: *04/11/2025*

Implemented [redacted] 05/20/2025)

236 - Staff Training

13. 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 A, hired [redacted]22, only had 1 hour of documented training relating to Dementia Care and Services during the 7/1/23 – 6/30/24 staff training year. The entire home is a secure dementia care unit.

Direct care staff person B[redacted]ired[redacted]22, had 0 (zero) hours of documented training relating to Dementia Care and Services during the 7/1/23-6/30/24 staff training year. The entire home is a secure dementia care unit.

Plan of Correction ***Accept [redacted]04/15/2025)***

The Director of Community Integration (DCI), completed a full audit on March 27, 2025 of all current staff persons training records during the 2023/2024 training year to identify all associates that do not have the 6 hours of mandatory dementia training.

All associates, except for those hired after July 1, 2024 will be required to attend a 2 day 12 hour training. Direct care staff will attend an additional day to receive 6 hours of dementia training.

The dates of the 18 hour (3 day training training):
Week of April 7th
Week of April 14th
Week of April 22nd
Week of April 29th

The Executive Director re-educated The Director of Community Integration on Monday, March 31, 2025 of regulation 236. Documentation of education shall be kept in accordance with 260.65i.

To ensure ongoing compliance with regulation 236, a new mandatory training sign off sheet has been created to ensure that all associates are receiving their 6 hours of mandatory dementia training. Ongoing monitoring / auditing of the form will be completed by the Executive Director and Director of Community Integration. See attached document.

Licensee's Proposed Overall Completion Date: *04/07/2025*

Implemented [redacted]05/20/2025)

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ARTIS SENIOR LIVING OF SOUTH HILLS* **License #:** *44916* **License Expiration:** *05/21/2025*

Address: *1001 HIGBEE DRIVE, BETHEL PARK, PA 15102*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name [redacted]

Legal Entity

Name: *ARTIS SENIOR LIVING OF BETHEL PARK LLC*

Addres [redacted]

Phone:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *124* **Waking Staff:** *93*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date:** *04/24/2025*

Inspection Dates and Department Representative

04/24/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served:** *62*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire Home* **Capacity:** *72* **Residents Served:** *62*

Hospice

Current Residents: *62*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *62*

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

Have Mobility Need: *62* **Have Physical Disability:** *2*

Inspections / Reviews

04/24/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/05/2025*

Inspections / Reviews *(continued)*

05/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/05/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/12/2025*

05/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/19/2025*

05/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/19/2025*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

On 4/14/25 at 6:59 a.m., resident #1's glucometer was used to measure resident #2's blood glucose level.

Repeat Violation 3/21/23 et al.

Plan of Correction ***Accept [redacted] 05/13/2025)***

On April 14, 2025, the Director of Health and Wellness during [redacted] glucometer audit identified that the glucometer readings were not correct for resident #1 and resident #2. She ordered new glucometers and they were replaced on April 24, 2025.

The agency nurse who worked on [redacted] 2025 has not worked a shift at Artis Senior Living since this date and was added to the Do Not Return listed on May 1, 2025.

Physician for Resident #1 and Resident #2 was notified of the shared glucometer on April 16, 2025. No recommendations were made by the physician. See attached for physician notifications.

On May 8, 2025, the Executive Director spoke to the [redacted] for Resident #1 and Resident #2 to notify them of the shared glucometer. They were both previously notified and knew that the glucometers have been replaced.

The Executive Director / Designee will review all glucometers daily until July 29, 2025 during the review of the glucometer readings to ensure that each glucometer is individually labeled, placed in their own labeled container and used for the designated resident.

All agency nurses will sign off an acknowledgement sheet regarding the expectation for blood sugar checks.

Beginning Thursday, May 1, 2025 the Executive Director / Designee will review glucometers daily for 90 days until Tuesday, July 29, 2029 to ensure that the readings match the individual resident glucometer. Beginning Wednesday, July 30, 2025 glucometer readings will be reviewed 3 times a week for 60 days until Saturday, September 27, 2025. Beginning Sunday, September 28, 2028 glucometer readings will be reviewed weekly for 30 days until Monday, October 27, 2025.

The Executive Director / Designee shall observe each staff person responsible for medication administration completing blood glucose checks and administration of insulin medication. Each staff will be observed once per week for a period of three months. This began during the week of May 12, 2025 and will conclude on August 15, 2025. Each staff will then be observed once per month for a period of three months. This will start on August 18, 2025 and will conclude on October 24, 2025. See attached for audit sheets.

Diabetic training will be scheduled in June 2025, September 2025 and December 2025 and will be required for all med techs and nurses to attend. Nurses and med techs previously attended training on March 31, 2025 and April 2, 2025. Documentation of education shall be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: *05/12/2025*

Implemented [redacted] 05/20/2025)

85a - Sanitary Conditions *(continued)*

183d - Prescription Current

2. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

At 3:31 p.m., there was a blister pack of Tramadol HCL 50 mg tabs in the Forbes Field medication cart with pharmacy label for resident #2 that indicated – Give one tablet by mouth every 6 hours as needed for severe pain. This medication was discontinued in December 2024.

Plan of Correction ***Accept [redacted] - 05/13/2025)***

The Director of Health and Wellness pulled the Tramadol HCL 50mg tab for Resident #2 out of the cart during the inspection of April 24, 2024.

Full Cart Audits were completed on April 28-30, 2025 by the Vice President of Health and Wellness of Artis Senior Living and the Executive Director. This was a 3-way audit (MAR, physician order, Med). All findings were corrected during the audit.

The Executive Director / Designee re-educate all nurses and med techs of violation 183d and Artis Senior Living's policy regarding discontinued medications by Friday, May 9, 205. Documentation of education shall be kept in accordance with 2600.65i.

Beginning on Monday, May 5, 2025, the Executive Director / Designee will audit 1 cart per week to ensure only current medications are in the med cart. This audit will be ongoing and findings will be reported in QA.

Omnicare Pharmacy who is our contracted pharmacy will complete full cart audits in June 2025, September 2025 and December 2025. This will be in addition to our weekly cart audits.

Licensee's Proposed Overall Completion Date: *05/12/2025*

Implemented ([redacted] 05/20/2025)

184a - Resident's Meds Labeled

3. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #3 is ordered insulin degludec (Tresiba Flextouch U-100) 100unit/mL – Inject 13 units into the skin every morning – subcutaneous. However, at 1:20 p.m., there was no pharmacy label on the flextouch pen that was in a plastic box with resident's name in the [redacted] neighborhood medication cart. The only pharmacy label was on the box of

184a - Resident's Meds Labeled (continued)

this medication located in the nursing office and indicated – inject 12 units subq every morning.

Resident #3 is ordered insulin aspart (Novolog) – Inject 10 units with breakfast, 3 units with lunch and 6 units with dinner, plus correctional sliding scale coverage. Max daily dose 37 units. 151-200=1 unit 201-250=2 units 251-300=3 units 301-350=4 units 351-400= 5 units >400= 8 units call MD. However, at 1:20 p.m., there was no pharmacy label on the flexpen pen that was in a plastic box with resident's name in the Kaufmann neighborhood medication cart. The only pharmacy label was on the box of this medication located in the nursing office and did not include the sliding scale directions.

Repeat Violation 3/21/23 et al.

Plan of Correction ***Accept [redacted]05/06/2025)***

Full Cart Audits were completed on April 28-30, 2025 by the Vice President of Health and Wellness of Artis Senior Living and the Executive Director. This was a 3-way audit (MAR, physician order, Med). All findings were corrected during the audit.

The Tresiba Flextouch U-1000 for Resident #3 was immediately placed in a bag and a label was obtained from the MAR and placed on the bag on 4/24/2025.

The (Novolog) for Resident #3 was immediately placed in a bag and a label was obtained from the MAR and placed on the bag on 4/24/2025. The Executive Director placed a copy of the sliding scale instructions in the bag on May 2, 2025. Colt RX will be reprinting the correct sliding scale instructions label and deliver them to the community on 5/5/2025.

The Executive Director / Designee will ensure that all insulin pens are correctly labeled during the weekly cart audits that will be performed beginning the week of May 5, 2025. The audit findings will be reported in QA.

Nurses and Med Techs will continue to complete audits for any medication changes and new medications received for their shift and ensure the medication labels are correct. This current audit will last for 90 days and conclude on June 21, 2025.

Beginning on Monday, May 5, 2025, the Executive Director / Designee will audit 1 cart per week to ensure that all prescription labels are correct. The audit findings will be reported in QA.

Licensee's Proposed Overall Completion Date: *05/12/2025*

Implemented [redacted]05/20/2025)

185a - Implement Storage Procedures

4. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #2 is ordered blood glucose checks 3 times daily before meals for sliding scale coverage. On the following dates/times, the blood glucose value was incorrectly entered on the resident's April 2025 medication administration record (MAR):

[redacted]

Resident #3 is ordered Baqsimi 3mg/actuation nasal spray, non-aerosol – Use 3mg in the nose as needed. However, at 1:20 p.m., this medication was not available in the home.

Resident #4 is ordered Azelaic Acid 15% gel – apply topically as directed to affected areas as needed for facial rosacea. However, at 2:53 p.m., this medication was not available in the home.

Repeat Violation 3/21/23 et al.

Plan of Correction ***Accept [redacted]05/06/2025)***

During a review of the findings on May 1, 2025 the Executive Director confirmed that the glucometer readings on 4/21/25 at 4:23 PM, 4/16/25 at 4:38 PM, 4/15/25 at 12:01 PM, and 4/12/25 at 3:42 PM are correct for resident #2. See attached for documentation. Executive Director spoke with [redacted]n May 2nd is discuss correction of violation findings.

The agency nurse through Clipboard Health who entered the blood sugar reading on 4/14/25 at 12:11 PM was added to the Do Not Return listed on May 1, 2025. The nurse has not worked a shift since [redacted]/25 at Artis Senior Living.

The medication for resident #3 (Baqsimi 3mg) was located in the community on May 1, 2025 and was placed in the cart to ensure that the medication was available for the resident. See attached for documentation of prescription fill date.

The medication for resident #4 (Azelaic Acid 15% gel) - Medication was re-ordered on 4/29/2025 by the Executive Director.

The Executive Director / Designee will review the medication exception report daily to identify any issues of medications not being available in the community.

185a - Implement Storage Procedures (continued)

Beginning Thursday, May 1, 2025 the Executive Director / Designee will review glucometers daily for 90 days until Tuesday, July 29, 2029 to ensure the blood glucose values are being entered correctly into the MAR. Beginning Wednesday, July 30, 2025 glucometer readings will be reviewed 3 times a week for 60 days until Saturday, September 27, 2025. Beginning Sunday, September 28, 2028 glucometer readings will be reviewed weekly for 30 days until Monday, October 27, 2025.

Beginning on Monday, May 5, 2025, the Executive Director / Designee will audit 1 cart per week ensure that all prescribed medications are available in the community. Audit findings will be reported at QA.

Licensee's Proposed Overall Completion Date: *05/12/2025*

Implemented [redacted] 05/20/2025)