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

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 **October 8,** **2025** until **April 8,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142792**

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: OCTOBER 8, 2025

[redacted]
Artis Senior Living of Lower Moreland LLC
[redacted]

RE: Artis Senior Living of Huntingdon Valley
2085 Lieberman Drive
Huntingdon Valley, Pennsylvania 19006
License #: 142792

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection May 21, 2025, July 14 and 15, 2025, and July 17, 2025 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 142791 dated March 11, 2025 to September 11, 2025 and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from OCTOBER 8, 2025 to APRIL 8, 2026.

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.

[redacted]

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
65a	III	61	$3	$183	15 calendar days from mailing date of this letter
65b	III	61	$3	$183	15 calendar days from mailing date of this letter
65e	III	61	$3	$183	15 calendar days from mailing date of this letter
65f	III	61	$3	$183	15 calendar days from mailing date of this letter
65g	III	61	$3	$183	15 calendar days from mailing date of this letter
183e	III	61	$3	$183	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

[redacted]

If you disagree with the decision to issue a SECOND 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 SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

This decision is final 31 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

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 HUNTINGDON VALLEY* **License #**: *14279* **License Expiration**: *09/11/2025*

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *ARTIS SENIOR LIVING OF LOWER MORELAND LLC*

Address: [redacted]

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**: *106* **Waking Staff**: *80*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *05/21/2025*

Inspection Dates and Department Representative

05/21/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *53*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *72* **Residents Served**: *53*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *53*

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

Have Mobility Need: *53* **Have Physical Disability**: *0*

Inspections / Reviews

05/21/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/21/2025*

Inspections / Reviews *(continued)*

06/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/28/2025*

07/24/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/27/2025*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

07/31/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *07/24/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 5/8/2025, at 6:30 am, staff person A struck resident 1. This incident was observed by staff person B. This incident was reported to staff person C on 5/8/2025. However, this allegation of abuse was not reported to the local area agency on aging until 5/9/2025 at 1:41 pm.

Plan of Correction ***Accept [redacted] - 07/02/2025)***

On 05/09/2025, the Executive Director took immediate action to review the PA 2600 code reporting incidents and the timeframe in which the reporting should occur. On 05/21/2025, in closing with exit interview, the Executive Director discussed 2600 15a with the State Surveyor. The Executive director has reviewed the code on reporting abuse and in the future will report allegations of abuse within the required 24-hour timeframe, to the local agency on aging.

In addition, beginning July 1st the Executive Director and the Director of Health and Wellness will meet to review the prior month's incident reports, and review procedures on reporting. This meeting will occur on the 1st business day of each month. The meeting will be conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *06/27/2025*

Not Implemented ([redacted] - 07/28/2025)

16c - Written Incident Report

2. Requirements

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

Description of Violation

On [redacted]/2025 at 6:30 am, Staff person A struck Resident 1. The home did not report this incident to the department until 5/9/2025 at 12:30 pm.

Plan of Correction ***Accept ([redacted] - 07/02/2025)***

On 05/09/2025, the Executive Director took immediate action to review the PA 2600 code reporting incidents and the timeframe in which the reporting should occur. On 05/21/2025, in closing with exit interview, the Executive Director discussed 2600 15a with the State Surveyor. The Executive director has reviewed the code on reporting abuse and in the future will report allegations of abuse within the required 24-hour timeframe, to the local agency on aging.
In addition, beginning July 1st the Executive Director and the Director of Health and Wellness will meet to review the prior month's incident reports, and review procedures on reporting. This meeting will occur on the 1st business day of each month. The meeting will be conducted by the Executive Director.

Licensee's Proposed Overall Completion Date: *06/27/2025*

16c - Written Incident Report *(continued)*

Not Implemented (- 07/28/2025)

42b - Abuse

3. 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 /2025 at approximately 6:30am, resident 1 came out of bedroom upset looking for their . Resident resides in Secured Dementia Care Unit(SDCU). Resident 1 approached staff person D who informed the resident their was not in the home in an attempt to de-escalate the resident from screaming as the resident appeared visibly agitated as they could not find their . Staff know from past incidents not to tell the resident their is deceased.

Resident 1 asked staff person A about the location of their which they responded, isn't here", the resident became more agitated and got closer to staff person A waving their finger in the staff person's face asking for their . Staff person A responded loudly to the resident saying, "Go head" and "Get your fingers out my face". Staff person D located at the beginning of the hall, and staff person B located in the middle of the hall, heard staff person A screaming at resident 1. Staff person B came out of a resident's room where they were providing care to offer assistance to de-escalate the situation. Staff person B witnessed staff person A strike the resident across the face. The resident did not fall or stumble, just stood there in shock.

Staff person B instructed staff person A to go to the employee break room while an assessment was completed on resident 1. Resident 1 was assessed with no immediate injuries. Staff person B contacted staff person C to report the incident. Staff person A was immediately suspended and sent home. Resident 1 was assessed intermittently by staff person C for bruising and discoloration of the face.

Plan of Correction Repeated Violation: 8/27/24 et al. ***Directed - 07/02/2025)***

In response to the violation on May 8, 2025, by the Pennsylvania Bureau of Human Service Licensing the Executive Director and Director of Health Wellness took immediate action. On 05/08/2025, the clinical department was in-serviced on the subject of abuse. The in-service was conducted by the Director of Health and Wellness. in addition, the subject of abuse education will continue to be emphasized in the annual trainings and in-services conducted throughout the year.

Staff person A was from Artis Senior Living of Huntingdon Valley at the conclusion of the investigation into this incident.

Proposed Overall Completion Date: 06/27/2025

Directed step of POC:

Within 3 days of the receipt of the plan of correction: *The administrator shall interview at least three residents a week for three months and biannually thereafter to ensure no residents are neglected, intimated, physically or verbally abused, mistreated or disciplined in any way, at any time. Documentation of interviews shall be kept.*

42b - Abuse *(continued)*

Directed Completion Date: *07/05/2025*

Not Implemented (07/28/2025)

82c - Locking Poisonous Materials

4. 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

Purell Advanced Hand Sanitizer, with a manufacture's label indicating "If swallowed, get medical help or contact Poison Control Center right away", was unlocked, unattended, and accessible to residents sitting in the activity room. None of the residents of the home, have been assessed capable of recognizing and using poisons safely.

Repeated Violation: 8/27/24 et al.

Plan of Correction ***Accept - 06/23/2025)***

In response to the violation on May 21, 2025, by the Pennsylvania Bureau of Human Service Licensing the Executive Director and Director of Community Integration took action. On May 22, 2025, all activities staff members were in-serviced on the subject of poison control. The in-service was conducted by the Director of Community Integration. Moving forward members of the activities team will be responsible for conducting visual observations daily, of the activities area(s), to verify, no poisons are accessible to the residents.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Not Implemented - 07/28/2025)

183e - Storing Medications

5. 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

Rosuvastatin 5 mg tab prescribed to resident 2 was punctured in slot 8 and the pill remained in place.

Olanzapine 2.5 mg tab prescribed to resident 2 was punctured in slot 7 and the pill remained in place.

Repeated Violation: 11/4/24, 8/27/24 et al.

Plan of Correction ***Accept - 07/02/2025)***

In response to the violation on May 21, 2025, by the Pennsylvania Bureau of Human Service Licensing the Executive Director and Director of Health Wellness took immediate action. The compromised pills from the blister packs were removed and discarded immediately. In addition, during bi-weekly cart audits, blister packs will be inspected by the nurse or med tech conducting the audit, to ensure the blister, pack of each medication, does not contain punctures, and are stored in an organized manner, under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions. The cart audits are currently in place and will remain in place indefinitely.

Licensee's Proposed Overall Completion Date: *06/27/2025*

183e - Storing Medications *(continued)*

Not Implemented [redacted] - 07/28/2025)

185a - Implement Storage Procedures

6. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 5/21/2025 at 2:55 pm, the glucometer for resident 3 was not calibrated to the correct time. The time shown on the glucometer was 13 minutes ahead of the current time.

Plan of Correction ***Directed ([redacted] - 07/02/2025)***

In response to the violation on May 22, 2025, by the Pennsylvania Bureau of Human Service Licensing the Executive Director and Director of Health Wellness took immediate action. The glucometer which was failing during the survey was replaced with a new glucometer. The glucometer will be inspected for calibration during bi-weekly cart audits and to ensure the glucometer is working properly.

In addition, the Coordinator of Health and Wellness, or the Director of Health and Wellness, will perform spot checks to ensure the continued accuracy of the glucometer.

Proposed Overall Completion Date: 06/27/2025

Directed step of POC:

Within 3 days of the receipt of the plan of correction: *The administrator or designated person shall conduct an initial and bi-weekly audit of all glucometers in the home to ensure they are working and calibrated for the correct date and time. Documentation of the audits shall be kept for review by the Department.*

Directed Completion Date: *07/05/2025*

Implemented [redacted] - 07/28/2025)

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**: *09/11/2025*

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *ARTIS SENIOR LIVING OF LOWER MORELAND LLC*

Address: [redacted]

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**: *124* **Waking Staff**: *93*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *07/14/2025*

Inspection Dates and Department Representative

07/14/2025 - On-Site: [redacted]

07/15/2025 - Off-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: *13*

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**: *0*

Inspections / Reviews

07/14/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2025*

08/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/27/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/13/2025*

08/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/27/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/27/2025*

08/28/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/27/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] 2025, at 12:02 PM, A family member of resident 1 reported a large bruise on resident 1's arm to staff person A. The bruise had 3 large scallop-like shapes and a single circle above it close to the resident's elbow on the lower half of [redacted] arm. The home investigated the incident. The home did not report this unexplained bruise or investigation to the local area agency on aging.

Plan of Correction ***Accept [redacted] - 08/13/2025)***

In response to the violation of 15(a) the investigation into the unexplained bruise has been reported to the local area on aging as of 08/06/2025. Moving forward all inquires and discoveries requiring investigation will be reported to the local area on aging. This reporting will be conducted by the Executive Director or the Director of Health and Wellness.

In addition, a monthly audit of the reportable & abuse reporting binder with be conducted by both the Executive Director & Director of Health and Wellness to confirm ongoing compliance. This monthly audit will begin August 12, 2025 and will be continuous and ongoing.
In addition

Licensee's Proposed Overall Completion Date: *08/12/2025*

Not Implemented ([redacted] - 08/28/2025)

16c - Written Incident Report

2. Requirements

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

Description of Violation

On [redacted]/2025, at 12:02 PM, A family member of resident 1 reported a large bruise on resident 1's arm to staff person A. The bruise had 3 large scallop-like shapes and a single circle above it close to the resident's elbow on the lower half of [redacted] arm. The home investigated the incident. The home did not report this unexplained bruise or investigation to the department.

Plan of Correction ***Accept ([redacted] 08/13/2025)***

In response to the violation of 16(c) the investigation into the unexplained bruise has been reported to the Department Personal Care Home Regional Office as of 08/06/2025. Moving forward all inquires and discoveries requiring investigation will be reported to the Department Personal Care Home Regional Office. This reporting will be conducted by the Executive Director or the Director of Health and Wellness.

In addition, a monthly audit of the reportable & abuse reporting binder with be conducted by both the Executive

16c - Written Incident Report (continued)

Director & Director of Health and Wellness to confirm ongoing compliance. This monthly audit will begin August 12, 2025 and will be continuous and ongoing.

Licensee's Proposed Overall Completion Date: *08/12/2025*

Not Implemented [redacted] - 08/28/2025)

17 - Record Confidentiality

3. 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 7/14/2025, at 11:39 AM, resident support plans were unlocked, unattended, and accessible in the upper cabinets of the 100-wing kitchen.

Repeat violation: 11/04/2024 and 08/27/2024 et al

Plan of Correction ***Accept [redacted] - 08/13/2025)***

On 07/15/2025, all records were removed from cabinetry and placed in secure locked cabinetry in the nurse's station. Moving forward, no records will be kept in any cabinetry on the neighborhoods, unless secure locks are first placed on the neighborhoods. This decision was made to prevent this from being an issue moving forward.

In addition, a daily checks of cabinetry will the housekeeping team to insure no records are left in unsecure areas of the community. Weekly audits of the daily checks will be conducted by Director Community Integration to confirm ongoing compliance. These daily checks and weekly audits will begin August 12, 2025 and will be continuous and ongoing.

Licensee's Proposed Overall Completion Date: *08/12/2025*

Implemented ([redacted] - 08/28/2025)

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

Staff person B hired on [redacted]/2025, had a background check completed on [redacted]/2022, which was over a year prior to the date of hire.

Staff person C hired on [redacted]/2025, had a background check completed on [redacted]/2022, which was over a year prior to the date of hire.

Agency staff person D, who's first date of work in the home is unknown, did not have a completed background check.

51 - Criminal Background Check (continued)

Repeat violation: 08/27/2024 et al

Plan of Correction ***Accept[redacted] - 08/13/2025)***

This violation was due to a misunderstanding as to how background checks are handled when using agency staffing. On 07/15/2025, background checks are being run for all staffing agency, by the business office manager, prior to the start of agency staffing shifts. Attached are a copy of all background checks for agency staffing.

In addition, a monthly audit of the agency binder will be conducted by the Executive Director or Director of Business Services to confirm ongoing compliance. This monthly audit will begin August 12, 2025 and will be continuous and ongoing.

Licensee's Proposed Overall Completion Date: *08/12/2025*

Not Implemented[redacted] - 08/28/2025)

65a - FS Orientation 1st Day

5. 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 C, whose first day of work was [redacted]/2025, 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.

Agency staff person D who's first date of work in the home is unknown stated during an interview that they 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.

Repeat violation: 11/04/2024 and 08/27/2024 et al

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

Plan of Correction ***Directed [redacted] - 08/13/2025)***

This violation was due to a misunderstanding as to how fire walks are handled when using agency staffing. Starting 07/15/2025 The Director of Environmental Services will conduct 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, the location and use of fire extinguishers, smoke detectors and fire alarms, and telephone use and notification of emergency services. This 1st Day Orientation will be provided to all staff including agency staff. [redacted] ***Not acceptable [redacted] 8/13/25***

In direct action to this violation Staff Person's C & D whom both serve as agency substitute staff will an orientation in general fire safety and emergency preparedness prior to their next shift. Should they select a shift at any point in the future.

Proposed Overall Completion Date: 08/12/2025

Directed steps of POC:

Immediately: *The administrator shall create a tracking system for new hires to ensure that newly-hired staff persons receive the training required by this regulation on or before the first work day and the documentation of training is kept in the staff person's record.*

Within 3 days of receipt of the plan of correction: *All staff persons involved in the hiring and retention of staff shall be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65(a). Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *08/16/2025*

Not Implemented ([redacted] - 08/28/2025)

82c - Locking Poisonous Materials

6. 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

Ecolab TRUPOWER Eco-Sans , with a manufacture's label indicating "DANGER: Contact poison control if swallowed", was unlocked, unattended, and accessible to residents under the sink in the 100-wing kitchen. Not all the residents of the home, including resident 1, have been assessed capable of recognizing and using poisons safely.

Repeat violation: 08/27/2024 et al

Plan of Correction ***Directed ([redacted] - 08/13/2025)***

In response to the violation of 82c, a secured cabinet has been created within the secure laundry room, on each

82c - Locking Poisonous Materials (continued)

neighborhood. In addition, the task list for housekeepers has been updated to include the daily task of ensuring, all cleaning products and poisons are secured in said cabinetry. The Director of Environmental Services will conduct daily checks, to ensure this task is being completed.

In addition, between the dates of 08/12/2025 & 08/26/2025 all staff members will be in-serviced on the topic of 2600.82c. This in-service will be conducted by Director of Environmental Services and/or The Executive Director.

Proposed Overall Completion Date: 08/12/2025

Directed Completion Date: *08/26/2025*

***Not** Implemented [redacted] - 08/28/2025)*

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On 7/14/2025 at 11:39 AM, an open food container, possibly containing a cake, was completely engulfed by gray/green mold making the item indistinguishable. This was found in the lower cabinets of the 100-wing kitchen.

Plan of Correction ***Accept** [redacted] 08/08/2025)*

In response to the violation of 85(a) the task of daily cabinetry check was added to the list of the culinary team. Each day, the culinary team will verify the cabinets on each neighborhood are maintained and sanitary. The Director of Culinary Services will be responsible for ensuring this task is completed daily and documented. This task will begin 07/25/2025

Licensee's Proposed Overall Completion Date: *08/06/2025*

***Implemented** [redacted] - 08/28/2025)*

88a - Surfaces

8. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The door in the main activities area was not in good repair and hanging off its hinges.

Plan of Correction ***Accept** [redacted] - 08/08/2025)*

In response to violation of 88(a), this violation was satisfied on 07/14/2025. The hinge had a missing screw and was repaired within minutes of being notified by the surveyor. The Director of Environmental Services conducts weekly checks of various areas of the community to ensure the floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. In addition to these weekly checks, a specific checklist has been created for floors, walls, ceilings, windows, and doors of each neighborhood and common areas. This too will be maintained and monitored by the Director of Environmental Services.

Licensee's Proposed Overall Completion Date: *08/06/2025*

***Implemented** [redacted] - 08/28/2025)*

183e - Storing Medications

9. 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 7/14/2025 at 10:47 AM a small white round pill was loose in the second drawer of the medication cart in the 300-wing.

Resident 2's blister pack of Mirtazapine 15 mg tablet was punctured at pill 10 and pill 3. The pills remained inside the packaging.

Repeat violation: 11/04/2024

Plan of Correction ***Accept [redacted] - 08/08/2025)***

In response to the violation of 183(e) a meeting was set with the packing provider, which took place on 07/24/2025. In this meeting it was determined that the best remedy for the issue would be additional adhesive backing, which is now added to the blister packing, during cart audits. Cart audits are conducted on a weekly basis. The cart audits are verified by the Director of Health and Wellness, and the Executive Director. The use of the additional adhesive backing began on 07/25/2025, when needed.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Not Implemented [redacted] - 08/28/2025)

184b - Labeling OTC/CAM

10. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 7/14/2025, a package of Vitamin d3 belonging to resident 3 was in the 200-wing medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept ([redacted] - 08/13/2025)***

In response to the violation of 184(b) the pharmacy was contacted immediately, and the proper labeling was provided for the Vitamin D3, by the pharmacy. Starting 07/15/2025, when a new resident is scheduled, the medications will be ordered directly from the pharmacy with no exception. This is to ensure that medications are received, with labeling in place. The ordering of medications will be performed by the charge nurse, and the Director of Health & Wellness.

Beginning August of 2025, a monthly cart audit will be performed by the Director of Health and Wellness to ensure compliance with 2600.184b.

Licensee's Proposed Overall Completion Date: *08/12/2025*

Implemented [redacted] - 08/28/2025)

185b - Medication Procedures

11. Requirements

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

The home's procedures for the safe use of medications and medical equipment do not include a process to investigate and account for missing medications and medication errors. The home's controlled medication policy does not include a process to log the time, the date, the person removing of controlled medications, and the remaining medication.

Plan of Correction ***Accept [redacted] - 08/13/2025)***

On 08/12/2025 action was taken to obtain updated policy from Artis Senior Living Updated Controlled Substance Policy Attached. Between 08/12/2025 to 08/26/2025 all staff members administering medications will trained regarding Artis Senior Living Controlled Substance Policy. The training will be conducted by the Executive Director or Director of Health and Wellness.

In addition,, a bi-weekly audit of all medication administration documentation will be conducted by the Director of Health and Wellness. These audits will be continuous and on-going.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Not Implemented [redacted] - 08/28/2025)

187b - Date/Time of Medication Admin.

12. 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

Resident 4 is prescribed Lorazepam .5 mg 3 times a day and Lorazepam 1 mg every 4 hours as needed for anxiety. Resident 4's 7/2025 controlled substance log details that Lorazepam 1 mg medication was removed on 7/13 at 10:59 AM and 2:00 PM, however resident 4's 7/2025 medication administration record (MAR) does not have the time or date this medication was administered. Resident 4's controlled substance log for Lorazepam .5 mg indicates that it was only removed on 7/13 at 5:12 PM, however the resident's 7/2025 MAR indicated that he/she received Lorazepam .5 mg at AM and noon on 7/13.

Repeat violation: 08/27/2024 et al

Plan of Correction ***Directed [redacted] 08/13/2025)***

In response to the violation of 187(b), on 07/15/2025, new labeling was created to make obvious and distinguish between the standing order and as needed orders. In addition, starting 07/22/2025 audits will be conducted by the

187b - Date/Time of Medication Admin. (continued)

DHW to ensure labeling is obvious and distinguishable for PRN vs Standing. These audits are conducted bi-weekly. Finally, the recording of the date and time of medication administration, and recording the name and initials of the staff person administering the medication will in-serviced regarding 2600.187b between 08/12/2025 & 08/26/2025. All staff administering medications will be in-serviced. The in-service will be conducted by the Director of Health and Wellness, or the charge nurse.

Proposed Overall Completion Date: 08/12/2025

Directed step of POC:

Within 3 days of the receipt of the plan of correction: *The administrator or designee qualified to administer medications shall review all resident MARs at least weekly and observe at least two medication passes of each staff person qualified to administer medications for two months to ensure the proper documentation of medication administration at the time of administration. Documentation of reviews shall be kept.*

Directed Completion Date: *08/16/2025*

Not Implemented [redacted] - 08/28/2025)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident 4 is prescribed Lorazepam .5 mg 3 times a day. However, resident 4 was administered Lorazepam 1 mg on 7/13/2025 at "AM" and noon.

Resident 5 is prescribed Lorazepam .5 mg every 12 hours. However, resident 5 did not receive this medication on 7/12 at "PM".

Repeat violation: 08/27/2024 et al

Plan of Correction ***Directed [redacted] - 08/13/2025)***

In response to the violation of 187(b), on 07/15/2025, new labeling was created to make obvious and distinguish between the standing order and as needed orders. In addition, starting 07/22/2025 audits will be conducted by the DHW to ensure labeling is obvious and distinguishable for PRN vs Standing. These audits are conducted bi-weekly. Finally, administering medications will in-serviced regarding Prescriber's Orders 2600.187d between 08/12/2025 & 08/26/2025. The in-service will be conducted by the Director of Health and Wellness, or the charge nurse.

Proposed Overall Completion Date: 08/12/2025

Directed step of POC:

Within 3 days of the receipt of the plan of correction: *The administrator or designee qualified to administer medications shall review all resident MARs at least weekly and observe at least two medication passes of each staff person qualified to administer medications for two months to ensure all prescribed medications are available,*

187d - Follow Prescriber's Orders *(continued)*

Directed Completion Date: *08/16/2025*

Not Implemented [redacted] - 08/28/2025)

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**: *09/11/2025*

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *ARTIS SENIOR LIVING OF LOWER MORELAND LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/20/2016* **Issued By**: *Township of Lower Moreland*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *122* **Waking Staff**: *92*

Inspection Information

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

Reason: *Renewal, Provisional, Monitoring* **Exit Conference Date**: *07/17/2025*

Inspection Dates and Department Representative

07/17/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *61*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire Facility* **Capacity**: *72* **Residents Served**: *61*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *61*

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

Have Mobility Need: *61* **Have Physical Disability**: *0*

Inspections / Reviews

07/17/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/17/2025*

Inspections / Reviews *(continued)*

08/20/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/17/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/23/2025*

08/25/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/22/2025*

Reviewer: [redacted] *on* **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/28/2025*

09/10/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/28/2025*

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 07/17/25, between 9:20 and 9:40, four task log books, containing confidential resident information, were observed unlocked, unattended, and accessible in each of the four residential wings of the home.

Repeat Violation: 11/04/24, 08/27/24 et. al.

Plan of Correction ***Accept [redacted] - 08/20/2025)***

On 07/18/2025, all records were removed from cabinetry and placed in secure locked cabinetry in the nurse's station. Moving forward, no records will be kept in any cabinetry on the neighborhoods, unless secure locks are first placed on the neighborhoods. This decision was made to prevent this from being an issue moving forward. In addition, a daily checks of cabinetry will the housekeeping team to insure no records are left in unsecure areas of the community. Weekly audits of the daily checks will be conducted by Director Community Integration to confirm ongoing compliance. These daily checks and weekly audits will begin August 12, 2025 and will be continuous and ongoing

Licensee's Proposed Overall Completion Date: *08/17/2025*

Implemented [redacted] - 09/02/2025)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/2025, for resident #1 was not signed by the resident.

Plan of Correction ***Accept [redacted] 08/20/2025)***

Within 5 days of receipt of POC, an audit of all resident files will be conducted to ensure all resident contracts have been signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

In addition, an audit of resident files will be conducted by the Executive Director within 48 hours or initial signing to ensure resident contracts are in compliance with 2600.25(b).

Licensee's Proposed Overall Completion Date: *08/17/2025*

Not Implemented [redacted] - 09/02/2025)

41e - Signed Statement

3. Requirements

2600.

41e - Signed Statement *(continued)*

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept [redacted] - 08/20/2025)***

Within 5 days of receipt of POC, an audit of all resident files will be conducted to ensure all resident files have been completed with a statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

In addition, an audit of resident files will be conducted by the Executive Director within 48 hours or initial signing to ensure resident contracts are in compliance with 2600.41(e).

Licensee's Proposed Overall Completion Date: *08/17/2025*

Not Implemented [redacted] - 09/02/2025)

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 A, whose first day of work was [redacted]/24, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, emergency evacuations, 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, telephone use and notification of emergency services.

Repeat Violation: 11/04/24, 08/27/24 et. al.

Plan of Correction ***Accept [redacted] - 08/20/2025)***

The administrator shall create a tracking system for new hires to ensure that newly-hired staff persons receive the training required by this regulation on or before the first work day and the documentation of training is kept in the staff person's record.

65a - FS Orientation 1st Day (continued)

In addition, all staff persons involved in the hiring and retention of staff
shall be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65(a). Documentation of education shall be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] 09/02/2025)

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 A completed their 40th scheduled work hour in December 2024. However, this staff person did not complete training in the following topics: 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.

Repeat Violation: 11/04/24, 08/27/24 et. al.

Plan of Correction ***Accept [redacted] - 08/20/2025)***

The administrator shall create a tracking system for new hires to ensure that newly-hired staff persons receive the training required by this regulation on or before the first work day and the documentation of training is kept in the staff person's record.
In addition, all staff persons involved in the hiring and retention of staff
shall be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65(a). Documentation of education shall be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: *08/21/2025*

Not Implemented [redacted] - 09/02/2025)

65e - 12 Hours Annual Training

6. 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 persons B, C and D did not complete any annual training hours in training year 2024.

65e - 12 Hours Annual Training (continued)

Repeat Violation: 08/27/24 et. al.

Plan of Correction ***Accept [redacted] 08/20/2025)***

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 08/12/2025 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: *08/17/2025*

Not Implemented [redacted] - 09/02/2025)

65f - Training Topics

7. 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 persons B, C and D 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, malnutrition and dehydration, personal care service needs of the resident, safe management techniques, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2024.

Repeat Violation: 08/27/24 et. al.

Plan of Correction ***Accept [redacted] 08/20/2025)***

Within 3 days of receipt of accepted Plan of Correction all direct care staff will receive 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

65f - Training Topics (continued)

what, how and who to report to if medications are observed unlocked in resident rooms. This training will be conducted by the Director of Health and Wellness, and/or Executive Director.
On 08/12/2025 the Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Executive Director. 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: *08/17/2025*

Not Implemented [redacted] - 09/02/2025)

65g - Annual Training Content

8. 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 persons B, C and D did not receive training in 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, 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 during training year 2024.

Repeat Violation: 08/27/24 et. al.

Plan of Correction ***Accept ([redacted] - 08/20/2025)***

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 Community Intergration.

On 08/12/2025 the Business Services Director received additional training for completing, storing, and auditing staff files. The person conducting the training was the Executive Director. 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

65g - Annual Training Content *(continued)*

Licensee's Proposed Overall Completion Date: *08/17/2025*

Not Implemented (- 09/02/2025)

82c - Locking Poisonous Materials

10. 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

Several items, including Multi-Surface Cleaner, Envirox Light Duty Cleaner and Hand Sanitizer, with a manufacturer's label indicating in some form; if ingested, contact a physician or Poison Control Center right away, were found unlocked, unattended, and accessible to residents on each wing of the home. The entire home is a secured dementia care unit and the residents are not capable of recognizing and using poisons safely.

Several items, including shampoo, deodorant, mouthwash, toothpaste and denture cleanser, with a manufacturer's label indicating in some form; if ingested, contact a physician or Poison Control Center right away, were found unlocked, unattended, and accessible to residents in resident rooms; 208, 214, 304 and 406. The entire home is a secured dementia care unit and the residents are not capable of recognizing and using poisons safely.

Repeat Violation: 05/21/25, 08/27/24 et. al.

Plan of Correction ***Accept - 08/20/2025)***

n response to the violation of 82c, a secured cabinet has been created within the secure laundry room, on each neighborhood. In addition, the task list for housekeepers has been updated to include the daily task of ensuring, all cleaning products and poisons are secured in said cabinetry. The Director of Environmental Services will conduct daily checks, to ensure this task is being completed.
In addition, between the dates of 08/12/2025 & 08/26/2025 all staff members will be in-serviced on the topic of 2600.82c. This in-service will be conducted by Director of Environmental Services and/or The Executive Director.

Licensee's Proposed Overall Completion Date: *08/26/2025*

Not Implemented - 09/02/2025)

89b - Hot Water Temperature

11. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 07/17/25, at 12:51 PM, the hot water temperature in room 110 measured 129 degrees Fahrenheit.

On 07/17/25, at 1:05 PM, the hot water temperature in room 214 measured 126.8 degrees Fahrenheit.

On 07/17/25, at 1:17 PM, the hot water temperature in room 406 measured 127.7 degrees Fahrenheit.

89b - Hot Water Temperature (continued)

Plan of Correction ***Accept [redacted] - 08/20/2025)***

On 07/17/2025, the Executive Director along with the Director of Environmental Services took immediate action to correct hot water temperatures in areas accessible to the resident exceeding 120 degrees Fahrenheit.

In addition, daily checks of water temperatures will be conducted by The Executive Director and/or The Director of Environmental Services.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Implemented [redacted] 09/02/2025)

132b - Safety Inspection/Fire Drill

13. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on January 16, 2025. However, a fire safety inspection and drill observed by a fire safety expert for 2024 could not be provided by the home.

Plan of Correction ***Accept[redacted] 08/20/2025)***

An annual fire safety inspection will be conducted by a fire safety expert in accordance with 2600.132(b). Documentation of the fire drill and fire safety inspection will be audited by The Executive Director no later than January 15th each year, to ensure compliance.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Implemented ([redacted] 09/02/2025)

132c - Fire Drill Records

14. 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 home has had 8 fire drills completed since the last inspection on 11/04/24. Of those, only two, on 02/23/25 and 03/23/25, had all required information documented on the written fire drill record.

The written fire drill record for drills conducted on 12/18/24, 04/03/25, 05/31/25 and 06/28/25 did not include: the amount of time it took for evacuation (recorded only with start and end time, no seconds listed), the exit route used, the number of residents in the home at the time of the drill and whether the fire alarm or smoke detector was operative.

The written fire drill record for the fire drill conducted on 11/18/24 did not include: the amount of time it took for

132c - Fire Drill Records (continued)

evacuation (recorded only with start and end time, no seconds listed), the exit route used and the number of residents in the home at the time of the drill.

The written fire drill record for the fire drill conducted on 01/26/25 did not include: the exit route used or the number of residents in the home at the time of the drill.

Plan of Correction ***Directed (08/25/2025)***

On 08/20/2025, the Executive Director conducted an in-service explaining regulation 2600.132(d) and the current violation. In attendance for the in-service was the Director of Environmental Services. Safety drills on all shifts are conducted by a third-party fire safety expert annually, and for all shifts. Records of these drills are maintained in the community's TELS database. A maximum safe evacuation time is being specified in writing by a third-party fire safety expert.
In addition, the home shall use documentation to include seconds when recording the start and end time of fire drills. This documentation will be audited monthly by The Director of Environmental Services, or The Executive Director to ensure compliance. These audits will begin September 1, 2025, and will be conducted within 24-48 hours following the performance of a fire drill.

Proposed Overall Completion Date: 08/22/2025

Directed

The administrator will monitor all fire drills and the fire drill records to ensure an unannounced fire drill is conducted at least once a month and is documented in the home's fire drill record which includes; the date, time, 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 activated. The administrator will request the fire alarm activity records for the fire alarm monitoring company and maintain these records with the home's fire drill record. 8/25/25

Directed Completion Date: *08/28/2025*

Implemented - 09/02/2025)

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 12/18/24 the "Start Time" is listed as "11 AM". The "End Time:" is listed as 11:30 AM. No other information is provided for the amount of time it took for evacuation making the evacuation time 30 minutes. The home has a maximum safe evacuation time of 15 minutes specified in writing by a fire safety expert on 01/16/25. The home states this has been the safe evacuation time for several years.

Repeat Violation: 11/04/24

132d - Evacuation *(continued)*

Plan of Correction ***Accept ([redacted]/25/2025)***

On 08/20/2025, the Executive Director conducted an in-service explaining regulation 2600.132(d) and the current violation. In attendance for the in-service was the Director of Environmental Services. Safety drills on all shifts are conducted by a third-party fire safety expert annually, and for all shifts. Records of these drills are maintained in the community's TELS database. A maximum safe evacuation time is being specified in writing by a third-party fire safety expert.

In addition, the home shall use documentation to include seconds when recording the start and end time of fire drills. This documentation will be audited monthly by The Director of Environmental Services, or The Executive Director to ensure compliance. These audits will begin September 1, 2025, and will be conducted within 24-48 hours following the performance of a fire drill.

Licensee's Proposed Overall Completion Date: *08/22/2025*

Not Implemented [redacted] - 09/02/2025)

191 - Resident Right to Refuse

16. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted [redacted]/25, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 08/20/2025)***

On 08/12/2025 action was taken to obtain updated policy from Artis Senior Living Resident's Right to Refuse.

In addition, within 5 days of receipt of POC, an audit of all resident files will be conducted to ensure all residents have been educated regarding Artis Senior Living Right to Refuse. The training will be conducted by the Executive Director and/or the Director of Health and Wellness.

Licensee's Proposed Overall Completion Date: *08/17/2025*

Not Implemented [redacted] - 09/02/2025)

233a - Lock Approval

17. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locks, used on the exit doors from the SDCU.

Plan of Correction ***Accept ([redacted] - 08/20/2025)***

On 08/12/2025 The Executive Director took action to obtain written approval from the local building authority for

233a - Lock Approval (continued)

magnetic locks used on the exit doors from SDCU. An inspection for the purpose obtained written approval has been scheduled and will be forwarded to the Department of Human Services by 08/22/2025.

Licensee's Proposed Overall Completion Date: *08/22/2025*

Not Implemented [redacted] - 09/02/2025)

236 - Staff Training

18. 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 persons B, C and D, who work in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2024 training year.

Repeat Violation: 08/27/24 et. al.

Plan of Correction ***Accept [redacted] - 08/20/2025)***

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 Community Intergration.

On 08/12/2025 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: *08/17/2025*

Implemented [redacted] - 09/02/2025)