



Pennsylvania Department of Human Services

Emailing date: May 12, 2026

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

RE: Artis Senior Living of Huntingdon Valley
2085 Lieberman Drive
Huntingdon Valley, Pennsylvania 19006
License #: 142790

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on February 18 and 19, 2026 and April 21, 2026, 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,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

May 11, 2026

[REDACTED]
ARTIS SENIOR LIVING OF LOWER MORELAND LLC
[REDACTED]
[REDACTED]

RE: ARTIS SENIOR LIVING OF
HUNTINGDON VALLEY
2085 LIEBERMAN DRIVE
HUNTINGDON VALLEY, PA, 19006
LICENSE/COC#: 14279

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/18/2026, 02/19/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: ARTIS SENIOR LIVING OF HUNTINGDON VALLEY **License #:** 14279 **License Expiration:** 04/08/2026
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:** 140 **Waking Staff:** 105

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Provisional, Incident **Exit Conference Date:** 02/19/2026

Inspection Dates and Department Representative

02/18/2026 - On-Site: [REDACTED]

02/19/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 72 **Residents Served:** 70

Secured Dementia Care Unit

In Home: Yes **Area:** entire home **Capacity:** 72 **Residents Served:** 70

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 70
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 70 **Have Physical Disability:** 0

Inspections / Reviews

02/18/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 04/20/2026

05/11/2026 - Document Submission

Submitted By: [REDACTED] **Date Submitted:** 04/20/2026

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

25b - Contract Signatures

1. 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]/25, for Resident #1 was not signed by the resident.

The resident-home contract, dated [REDACTED]/26, for Resident #2 was not signed by the resident.

Repeat Violation Date: 7/17/25

Plan of Correction

Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction [REDACTED] - 3/30/26)

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall offer resident #1 and #2 an opportunity to review and sign the contract. The home shall notate if a resident is unable to sign and provide the department with documentation of the inability to sign. If a resident refuses to sign, the administrator/designee shall offer the contract at least two more times on differing days, documenting each refusal in writing.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit all current resident contracts for the presence of signatures, and correct any contract as described in the methods above.

Beginning 15 days from the receipt of the acceptable plan of correction, the administrator shall audit all new contracts monthly for 6 months.

Directed Completion Date: 04/09/2026

Implemented [REDACTED] 05/11/2026)

26b - Quality Management Plan Content

2. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's quality management meeting review dated 3/13/25 do not address the reportable incident and condition reporting procedures, complaint procedures, licensing violations and plans of correction, resident or family councils.

Plan of Correction

Directed ([REDACTED] 03/30/2026)

Directed Plan of Correction (CM - 3/30/26):

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall develop and implement a quality management plan which includes a review of all of the all required components in accordance with regulation 2600.26b.

26b - Quality Management Plan Content (continued)

Beginning 10 days from the receipt of the acceptable plan of correction, the administrator shall schedule and conduct a periodic review of the quality management plan at least annually.

Directed Completion Date: 04/09/2026

Implemented (█ - 05/11/2026)

41e - Signed Statement**3. Requirements**

2600.

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.

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Repeat Violation Date: 7/17/25

Plan of Correction

Directed (█ - 03/30/2026)

Directed Plan of Correction (█ - 3/30/26):

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall present the statement for resident #1 and #2's acknowledgment of the receipt of resident rights and complaint procedures. If a resident is unable to sign, administrator or designee shall indicate the date that this was reviewed/presented, notate the statement, and provide documentation of the resident's inability to the department. If a resident refuses to sign, the administrator or designee shall present the statement on at least two separate additional dates, notating each date and refusal on the document.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee will review all resident records to ensure each resident has received a copy of the resident rights and there is documentation each resident and, if applicable, the resident's designated person have received a copy of the resident rights.

Starting 15 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit all new resident records to ensure the requirements of 2600.41e have been met.

Directed Completion Date: 04/09/2026

Implemented (█ - 05/11/2026)

54a - Direct Care Staff**4. Requirements**

2600.

54a - Direct Care Staff (continued)

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

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

Description of Violation

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

Plan of Correction

Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction (CM - 3/30/26):

Immediately, the administrator or designee shall remove staff person A from the responsibilities of providing direct care tasks to residents.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall review all current direct care staff records to ensure all direct care staff persons meet the qualifications in accordance with regulation 2600.54(a) to include a Diploma issued by the Pennsylvania Department of Education or Department of Education in another state. Documentation shall be kept in the staff records. Only those staff persons who meet the direct care staff qualifications will provide direct care services.

Within 10 days of the receipt of the acceptable plan of correction,, the administrator or designee shall educate all staff persons involved in the hiring and retention of staff, including the administrator, on the direct care staff educational qualifications. Documentation of training shall be kept.

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall develop and implement a system to ensure that all direct care staff meet the qualifications in accordance with regulation 2600.54(a) before providing any direct care services.

Directed Completion Date: 04/14/2026

Implemented [REDACTED] 05/11/2026)

64c - Annual Training

5. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person B, the [REDACTED], completed only 5 hours of Department-approved annual training in training year 2025.

Plan of Correction

Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction (CM - 3/30/26):

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall schedule approved education for remedial training of 19 hours to compensate for missed hours of education in the 2025 training year.

64c Annual Training (continued)

At least 10 hours of compensatory education shall be completed by 4/30/26.

Within 10 days of the receipt of the acceptable plan of correction, the administrator of designee shall develop and implement a 2026 schedule of training for administrator A, which includes a total of 43 hours of training to be completed by 12/31/26 (19 hours for 2025 and 24 hours for 2026.) The training schedule shall be submitted to the attention of [REDACTED] Office.

Starting 15 days from the receipt of the acceptable plan of correction, administrator training shall be monitored monthly and through the quality management process to ensure each administrator has 24 hours of Department approved training. annually.

Directed Completion Date: 04/19/2026

Implemented [REDACTED] - 05/11/2026

65a - FS Orientation 1st Day**6. 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]/25, 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
- Telephone use and notification of emergency services

Staff person D, 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, 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

65a FS Orientation 1st Day (continued)

- The location and use of fire extinguishers
- Smoke detectors and fire alarms
- Telephone use and notification of emergency services

Staff person E, whose first day of work was [REDACTED]/25, 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
- Telephone use and notification of emergency services

Repeat Violation Date: 7/17/25; 7/14/25 et al

Plan of Correction

Directed [REDACTED] 03/30/2026)

Directed Plan of Correction (CM - 3/30/26):

Within 10 days of the receipt of the acceptable plan of correction, staff C,D, and E shall receive compensatory training on missed orientation topics.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit orientation records for all employees hired within the past two years to ensure orientation topics were presented in accordance with 2600.65a. Documentation of audits shall be kept.

Within 15 days of the receipt of the acceptable plan of correction, all staff persons involved in the hiring and retention of staff will 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 will be kept.

Starting 15 days from the receipt of the acceptable plan of correction, the administrator or designee shall review all new staff person training records to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in general fire safety and emergency preparedness in accordance with regulation 2600.65a, monthly for 6 months.

Directed Completion Date: 04/14/2026

Implemented [REDACTED] - 05/11/2026)

65b - Rights/Abuse 40 Hours**7. 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.

65b - Rights/Abuse 40 Hours (continued)

- 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 C completed their 40th scheduled work hour on approximately 10/29/25; however, this staff person did not complete training in the following topics:

- Resident rights
- Emergency medical plan
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)
- Reporting of reportable incidents and conditions

Staff person D completed their 40th scheduled work hour on approximately 7/17/24; however, this staff person did not complete training in the following topics:

- Resident rights
- Emergency medical plan
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)
- Reporting of reportable incidents and conditions

Staff person E completed their 40th scheduled work hour on approximately 10/22/25; however, this staff person did not complete training in the following topics:

- Resident rights
- Emergency medical plan
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)
- Reporting of reportable incidents and conditions

Repeat Violation Date: 7/17/25

Plan of Correction

Directed [REDACTED] 03/30/2026)

Directed Plan of Correction [REDACTED] - 3/30/26):

Within 10 days of the receipt of the acceptable plan of correction, staff C,D, and E shall receive compensatory training on missed training topics.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit training records for all employees hired within the past two years to ensure orientation topics were presented in accordance with 2600.65b. Documentation of audits shall be kept.

Within 15 days of the receipt of the acceptable plan of correction, all staff persons involved in the hiring and retention of staff will be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65b. Documentation of education will be kept.

65b - Rights/Abuse 40 Hours (continued)

Starting 15 days from the receipt of the acceptable plan of correction, the administrator or designee shall review all new staff person training records to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed training topics in accordance with regulation 2600.65b, monthly for 6 months.

Directed Completion Date: 04/14/2026

Implemented [REDACTED] - 05/11/2026)

65f - Training Topics**8. Requirements**

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self administration during the 2025 training year.

Direct care staff person F did not receive training in medication self administration during the 2025 training year

Repeat Violation Date: 7/17/25

Plan of Correction

Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction [REDACTED] - 3/30/26):

Within 10 days of the receipt of the acceptable plan of correction, staff person A and F shall receive compensatory training in medication self-administration.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit training records for all direct care staff hired within the past two years to ensure orientation topics were presented in accordance with 2600.65f. Documentation of audits shall be kept.

Within 15 days of the receipt of the acceptable plan of correction, all staff persons involved in the hiring and retention of staff will be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65f. Documentation of education will be kept.

Starting 15 days from the receipt of the acceptable plan of correction, the administrator or designee shall review all new staff person training records to ensure all direct care staff persons have completed all annual training topics in accordance with 2600.65f, monthly for 6 months.

Directed Completion Date: 04/14/2026

65f Training Topics (*continued*)*Implemented (█ - 05/11/2026)*

82c Locking Poisonous Materials

9. Requirements

2600.

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

Description of Violation

On 2/18/26, Disinfecting Acid Bathroom Cleaner, with a manufacturer's label indicating "call a poison control center if ingested", was unlocked, unattended, and accessible to residents under the sink in the kitchenette of section 300. Colgate toothpaste with a manufacturer's label indicating "get medical help or contact a poison control center if ingested" was observed in Resident #3's bathroom. Crest toothpaste with a manufacturer's label indicating "get medical help or contact a poison control center if ingested" was observed in Resident #4's bathroom. Not all of the residents of the home, including residents #12 and #13, have been assessed capable of recognizing and using poisons safely.

Repeat Violation Date: 7/17/25; 7/14/25 et al; 5/21/25

Plan of Correction*Directed (█ - 03/30/2026)***Directed Plan of Correction (CM - 3/30/26):**

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit all areas of the home to ensure that poisonous materials, products, etc. are locked and and inaccessible to residents.

Starting immediately, the administrator or designee shall monitor the home weekly for 6 months to ensure poisonous materials are locked and inaccessible to residents.

Directed Completion Date: 04/09/2026

Implemented (█ - 05/11/2026)

85a Sanitary Conditions

10. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/18/26, Staff Member G administered medications to Resident #2. Staff Member G did not properly sanitize their hands before or after administration. Staff Member G touched Resident #2's medications with ungloved hands and placed them into Resident #2's hands one by one.

Plan of Correction*Directed (█ - 03/30/2026)***Directed Plan of Correction (CM - 3/30/26):**

85a Sanitary Conditions (continued)

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall educate all staff qualified to administer medications on proper hand hygiene and sanitary practices regarding medication administration.

Starting 10 days from the receipt of the acceptable plan of correction, the administrator or designee shall observe at least 5 medication passes per week, on all shifts, to ensure proper hand hygiene and sanitary administration of medications, to continue for two months.

Directed Completion Date: 04/09/2026

Implemented [REDACTED] - 05/11/2026)

101j7 - Lighting/Operable Lamp**11. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #5 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction [REDACTED] 3/30/26):

Immediately, the administrator or designee shall ensure that a source of light that can be turned on/off at resident #5's bedside is in place and operational.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall educate all direct care staff persons and housekeeping staff on the importance of operable bedside lighting and that each resident shall have an operable lamp or other source of lighting that can be turned on/off from bedside. Documentation of education shall be kept.

Beginning within 10 days from the receipt of the acceptable plan of correction, the administrator or designee shall check the home at least weekly to ensure all resident beds have an operable bedside lamp or source of lighting that can be turned on/off from bedside for three months.

Directed Completion Date: 04/09/2026

Implemented [REDACTED] - 05/11/2026)

132f - Alternate Exit Routes**12. Requirements**

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

Behind the fire doors" was the only exit route used during the fire drills held from 7/2025 through 1/2026.

132f - Alternate Exit Routes (continued)

Plan of Correction Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction (CM - 3/30/26):

Within 5 days of the receipt of the acceptable plan of correction, the administrator or designee shall educate all staff on the location of all emergency exits in the home and the requirement to alternate exits during fire drills.

Beginning 5 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit monthly documentation of fire drills to ensure alternate exits are used.

Directed Completion Date: 04/04/2026

Implemented [REDACTED] - 05/11/2026)

132g - Fire Drills Days/Times

13. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the end of the month as evidenced by the following drills: 1/31/26; 11/30/25; 10/31/25; 9/29/25; 7/31/25.

Plan of Correction Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction [REDACTED] - 3/30/26):

Within 5 days of the receipt of the acceptable plan of correction, the administrator shall educate all staff involved in the planning and execution of fire drills of the requirements of 2600.132g.

Beginning 5 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit monthly documentation of fire drills to ensure that fire drills are held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present, and not routinely held at times when resident attendance is low.

Directed Completion Date: 04/04/2026

Implemented [REDACTED] - 05/11/2026)

183e - Storing Medications

14. 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 2/18/26, the following medication cards were observed to have a punctured blister foil with the medication still present in the spot- exposing it to contamination or improper sanitation:

183e - Storing Medications (continued)

- Resident #1's Acetaminophen 325mg tab
- Resident 6's Acetaminophen 325mg tab

Resident #7 is prescribed Basaglar Pen- inject 3 units subcutaneously at bedtime. The pen was opened 1/16/26. Manufacturer's instructions indicate this medication should be discarded 28 days after opening. The pen was still available in the medication cart as of 2/18/26.

Resident #7 is prescribed Admelog Sclo Inj 100u/ml pen- inject 10 units subcutaneously three times per day at breakfast, lunch and dinner. The pen was opened 1/16/26. Manufacturer's instructions indicate this medication should be discarded 28 days after opening. The pen was still available in the medication cart as of 2/18/26.

Resident #8 is prescribed Brimonidine eye drops- instill one drop into the affected eye every 12 hours. The eye drops were opened on 1/14/26. Manufacturer's instructions indicate Brimonidine eye drops should be discarded 28 days after opening. The eye drops were still available in the medication cart as of 2/18/26.

Resident #8 is prescribed Latanaprost 0.005% eye drops- instill one drop into left eye nightly. The eye drops were opened on 1/16/26. Manufacturer's instructions indicate Latanaprost 0.005% eye drops should be discarded 28 days after opening. The eye drops were still available in the medication cart as of 2/18/26.

Resident #9 is prescribed Latanaprost 0.005% eye drops- instill one drop into each eye nightly. The eye drops were opened on 1/13/26. Manufacturer's instructions indicate Latanaprost 0.005% eye drops should be discarded 28 days after opening. The eye drops were still available in the medication cart as of 2/18/26.

Resident #10 is prescribed Latanaprost 0.005% eye drops- instill one drop into each eye nightly. The eye drops were opened on 1/13/26. Manufacturer's instructions indicate Latanaprost 0.005% eye drops should be discarded 28 days after opening. The eye drops were still available in the medication cart as of 2/18/26.

Repeat Violation Date: 7/14/25 et al; 5/21/25

Plan of Correction

Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction [REDACTED] - 3/30/26):

Within 5 days of the receipt of the acceptable plan of correction, the administrator or designee shall perform cart audits to ensure that all resident medications are stored in accordance with 2600.183e.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall educate all staff qualified to administer medications on the proper storage of medications, in accordance with 2600.183e.

Starting within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit all medication carts weekly for two months, then monthly for three months.

Directed Completion Date: 04/09/2026

Implemented [REDACTED] - 05/11/2026)

187b - Date/Time of Medication Admin.

15. Requirements

2600.

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

Description of Violation

On 2/18/26, during a scheduled medication pass, Staff Member G administered Carvedilol tab 3.125mg, Duloxetine Cap 60mg DR, Famotidine Tab 40mg, Ferrous Sulf tab 325mg, Gabapentin Cap 100mg, Levothyrozin tab 137mcg, Losartan Pot tab 25mg, Metformin tab 500mg, Olanzipine tab 2.5mg, Vitamin B-12 tab 1000mcg and Vitamin D tab 1000 unit to Resident #2. Staff Member G did not initial the resident's medication administration record (MAR) at the time of administration. Instead, Staff Member G told Staff Member F that Resident #2 took their medications and Staff Member F stated they would initial the MAR as they were taking the medication cart to another area of the home.

The medication administration record (MAR) for Resident #11 showed the resident was given Hydralazine 50mg tab (take one tablet by mouth every 8 hours for hypertension) on 2/5/26 at 10:00pm; however, the MAR was not initialed until 12:04am with a note that this medication was passed on the previous shift. The MAR was not initialed at the time of administration.

Repeat Violation Date: 7/14/25 et al

Plan of Correction

Directed (████) - 03/30/2026)

Directed Plan of Correction (████) - 3/30/26):

Immediately, the administrator or designee qualified to administer medications will complete an initial audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b).

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall educate all staff qualified to administer medications on the on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of education shall be kept.

Starting within 10 days of the receipt of the acceptable 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 weekly 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: 04/09/2026

Implemented (████) - 05/11/2026)

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.

191 - Resident Right to Refuse (continued)

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.

Resident #2, admitted [REDACTED] /26, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeat Violation Date: 7/17/25

Plan of Correction

Directed ([REDACTED] - 03/30/2026)

Directed Plan of Correction ([REDACTED] - 3/30/26):

Immediately, the administrator or designee shall educate residents #1 and #2 on the residents' right to question or refuse medication if the resident believes there may be a medication error. Documentation shall be kept.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall educate all staff persons involved in the admissions process of educating residents on the right to question of refuse medication if the resident believes there may be a medication error and documenting the education.

Starting within 10 days of the receipt of the acceptable plan of correction, the administrator or designee will review all newly admitted resident records to ensure all residents have been educated on the right to question of refuse medication if the resident believes there may be a medication error and the proper documentation is in the resident's record monthly for three months.

Directed Completion Date: 04/09/2026

Implemented ([REDACTED] - 05/11/2026)

201 - Positive Interventions

17. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

On 12/28/25 at 9:20am, a resident-to-resident altercation occurred between Resident #12 and Resident #13. Per the incident report filed by the home, Staff Member E got between Residents #12 and #13 and held Resident #12's hands to prevent further contact with Resident #13. Staff Member E did not implement positive interventions to modify or eliminate the behaviors of Resident #12.

Plan of Correction

Directed ([REDACTED] - 03/30/2026)

Directed Plan of Correction ([REDACTED] - 3/30/26):

Immediately, the administrator or designee shall observe and monitor the care and services of residents in the

201 Positive Interventions (continued)

home for at least two residents per week for three months and biannually thereafter to ensure the residents are receiving the care and services indicated in the resident's support plans and the use of positive interventions is implemented. Documentation of monitoring shall be kept.

Within 20 days of the receipt of the acceptable plan of correction, all direct care staff and management staff, will receive training in positive interventions and safe management techniques from an Alzheimer/Dementia Care Specialist, Department approved outside source. Documentation of education shall be kept in the staff records.

Directed Completion Date: 04/19/2026

Implemented [REDACTED] - 05/11/2026)

202 - Prohibitions**18. Requirements**

2600.

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On 12/28/25 at 9:20am, a resident to resident altercation occurred between Resident #12 and Resident #13. Per the incident report filed by the home, Staff Member E got between Residents #12 and #13 and held Resident #12's hands to prevent further contact with Resident #13. Staff Member E did not implement positive interventions to modify or eliminate the behaviors of Resident #12. The use of manual restraints are prohibited.

Plan of Correction

Directed [REDACTED] - 03/30/2026)

Directed Plan of Correction ([REDACTED] - 3/30/26):

Immediately, the administrator or designee shall observe and monitor the care and services of residents in the home for at least two residents per week for three months and biannually thereafter to ensure the residents are receiving the care and services indicated in the resident's support plans and the use of positive interventions is implemented. Documentation of monitoring shall be kept.

Within 20 days of the receipt of the acceptable plan of correction, all direct care staff and management staff, will

202 Prohibitions (continued)

receive training in positive interventions and safe management techniques from an Alzheimer/Dementia Care Specialist, Department approved outside source. Documentation of education shall be kept in the staff records.

Directed Completion Date: 04/19/2026

Implemented (████) - 05/11/2026)

234a - Admission Support Plan**19. Requirements**

2600.

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

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on █████/26; however, the resident's initial support plan was completed on 2/4/26.

Plan of Correction

Directed (████) - 03/30/2026)

Directed Plan of Correction (████) 3/30/26):

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall educate all staff persons involved with the completion of support plans on the proper completion and accuracy of the support plans including the documentation of the care and services the home will provide to each resident. This education will also include the requirement that each resident shall have a support plan completed within 72 hours of admission to the SDCU. Documentation of education will be kept.

Beginning 10 days from the receipt of the acceptable plan of correction the administrator or designated staff person shall audit all new resident admissions to ensure all newly admitted residents have a support plan completed in accordance with regulation 2600.234(a), monthly for three months.

Directed Completion Date: 04/09/2026

Implemented (████) - 05/11/2026)

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

May 11, 2026

[REDACTED]
ARTIS SENIOR LIVING OF LOWER MORELAND LLC
[REDACTED]
[REDACTED]

RE: ARTIS SENIOR LIVING OF
HUNTINGDON VALLEY
2085 LIEBERMAN DRIVE
HUNTINGDON VALLEY, PA, 19006
LICENSE/COC#: 14279

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/21/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED] e [REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: ARTIS SENIOR LIVING OF HUNTINGDON VALLEY **License #:** 14279 **License Expiration:** 04/08/2026
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: 1 2 **Date:** 10/13/2016 **Issued By:** Township of Lower Moreland

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 142 **Waking Staff:** 107

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Monitoring **Exit Conference Date:** 04/21/2026

Inspection Dates and Department Representative

04/21/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 72 **Residents Served:** 71

Secured Dementia Care Unit

In Home: Yes **Area:** Entire Home **Capacity:** 72 **Residents Served:** 71

Hospice

Current Residents: 8

Number of Residents Who:

Receive Supplemental Security Income: NA **Are 60 Years of Age or Older:** 71
Diagnosed with Mental Illness: NA **Diagnosed with Intellectual Disability:** NA
Have Mobility Need: 71 **Have Physical Disability:** NA

Inspections / Reviews

04/21/2026 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 05/14/2026

Inspections / Reviews (*continued*)

05/07/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/11/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 05/12/2026

05/11/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/11/2026

Reviewer: [REDACTED]

Follow Up Type: Bypass Document
Submission

05/11/2026 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/11/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

54a - Direct Care Staff

1. Requirements

2600.

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

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

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

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

Plan of Correction**Directed** [REDACTED] - 05/11/2026)

In response to the violation of PA 2600.54a the Director of Health and Wellness took immediate action and staff person A and staff person B were removed from the schedule of direct care until such time as a waiver can be received, GED obtained, or a active registry status on the Pennsylvania nurse aide registry be produced.

On 04/21/2026 the executive director and director of health and wellness vetted the schedule to ensure there were no staff members administering direct care while being out of compliance with PA 2600.54a

The executive director shall audit all new staff members records from the period 04/22/2026 thru 12/31/2026, to ensure ongoing compliance with PA 2600.54a

Proposed Overall Completion Date: 05/08/2026

Directed Plan of Correction (5/11/26 - [REDACTED]):

To clarify the above plan of correction, beginning immediately, the administrator shall conduct monthly audits of newly hired direct care staff to ensure all of the requirements of 54a are met prior to the staff performing unsupervised direct care tasks.

Directed Completion Date: 05/12/2026

Implemented [REDACTED] - 05/11/2026)

65d - Initial Direct Care Training

2. Requirements

2600.

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

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person C, hired on [REDACTED]/2023, began providing unsupervised ADL services on 4/21/2026. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

65d - Initial Direct Care Training (*continued*)**Plan of Correction****Directed** [REDACTED] - 05/11/2026)

In response to the violation of PA 2600.65d, 04/21/2026 the executive director took immediate action and removed staff member C from the schedule of rendering unsupervised ADL services, until completing the Department-approved direct care training course and passing the competency test.

Staff member C then took immediate action and began the department approved course and passed the competency test. Please see attached proof of compliance.

On 04/22/2026 the executive director conducted an audit of all staff records to ensure compliance with PA 2600.65(d). The executive director shall audit all new staff members records from the period 04/22/2026 thru 12/31/2026, to ensure ongoing compliance with PA 2600.65(d).

Proposed Overall Completion Date: 05/08/2026

Directed Plan of Correction (5/11/26 - [REDACTED]

To clarify the above plan of correction, beginning immediately, the administrator shall conduct monthly audits of newly hired direct care staff to ensure all of the requirements of 65d are met prior to the staff performing unsupervised direct care tasks.

Directed Completion Date: 05/12/2026

Implemented [REDACTED] - 05/11/2026)

183e - Storing Medications

3. 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 4/21/2026, Quetiapine Tab 25mg for Resident 1, the blister pack was punctured in slot 4 and the pill remained in place.

On 4/21/2026, Carbamazepin Chew 100mg for Resident 2, the blister pack was punctured in slot 8 and the pill remained in place.

Plan of Correction**Accept** [REDACTED] - 05/11/2026)

In response to the violation of PA 2600.183e on 04/15/2026, the executive director and director of health and wellness had begun the process of addressing blister packet punctures. The service provider was consulted and the solution of providing multi-drug packaging, with a cardboard backing was deemed to be the most suitable manner of addressing the issue. The predominant cause of the issue was noted to be spacing inside the cart. In the mid-May 2026, the service provider will provide training to all medication administration staff and nursing. The start of use date is scheduled for May 28, 2026.

183e Storing Medications (continued)

Weekly cart audits will be conducted beginning 04/22/2026 and remain in place until 12/31/2026, at a minimum. The person in charge of cart audits will be the Director of Health & Wellness.

Please see attached documentation between leadership and the service provider.

Licensee's Proposed Overall Completion Date: 05/08/2026

Implemented ([REDACTED] - 05/11/2026)