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

August 8, 2025

[redacted], ADMINISTRATOR
ARTIS SENIOR LIVING OF LEMOYNE LLC
[redacted]

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/12/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARTIS SENIOR LIVING OF WEST SHORE* **License #**: *33370* **License Expiration**: *12/01/2025*

Address: *150 NORTH 12TH STREET, LEMOYNE, PA 17043*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *ARTIS SENIOR LIVING OF LEMOYNE LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *128* **Waking Staff**: *96*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *06/12/2025*

Inspection Dates and Department Representative

06/12/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home is SDCU* **Capacity**: *64* **Residents Served**: *64*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

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

Have Mobility Need: *64* **Have Physical Disability**: *0*

Inspections / Reviews

06/12/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/13/2025*

07/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/06/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/21/2025*

Inspections / Reviews *(continued)*

07/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/06/2025*

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

08/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/06/2025*

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

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted], at approximately 7:25 PM, resident #3 found resident #2 was found lying in another resident's bed. Resident #3 walked into the room and attempted to get resident #2 out of the bed. Then resident #2 hit resident #3 in the mouth, grabbed resident #3 by [redacted] wrist and scratched resident #3's [redacted] arm. As a result of the incident, resident #3 sustained a bleeding lip, a scratch to the underside of [redacted] forearm as well as pain and swelling to [redacted] wrist.

On [redacted], at approximately 10:00 AM, while staff person A and B were giving resident #1 a shower. Resident #1 began swinging and punching at staff person A and B. Then staff person B then observed grab and hold resident #1's [redacted] arm. As a result, resident #1 sustained skin tears on [redacted] arm. Staff person A was terminated as a result of the incident.

Repeated Violation - 10/30/24 and 7/9/24, et al

Plan of Correction ***Accept ([redacted] - 07/16/2025)***

Staff members intervened in both listed cases, and no further harm came to any resident. Residents were monitored hourly for 72 hours. Residents were monitored for any further interactions following the incident and no further altercations occurred.
Staff members were altered to the incidents via the communities 24 hours report and shift huddles.
Residents support plans were updated by the Director of Health and Wellness to reflect the behaviors on 7/1/2025, adjustments will be made to the support plan as needed.
This hourly monitoring will continue for resident #2 to ensure no further behaviors occur, and any updates.
All staff education on Abuse and Neglect was conducted on 6/26/2025, by the executive director and health and wellness director.
Monthly staff meetings including abuse and neglect will be conducted by the executive director or designee for three months starting on 7/24/2025.
Resident #2 is being monitored hourly to prevent reoccurrences of behaviors.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented ([redacted] - 08/07/2025)

82c - Locking Poisonous Materials

2. 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.

82c - Locking Poisonous Materials *(continued)*

Description of Violation

On 6/12/25, at approximately 3:30 PM, an open toothpaste bottle in a toothbrush holder and a box of unopened toothpaste was discovered in room #416. These items had a label stating, "Keep out of reach of children" and "If more than is used for brushing is accidently swallowed, seek medical attention or contact poison control center." None of the residents in the home are assessed to be safe around poisons.

Repeated Violation - 7/9/24, et al

Plan of Correction ***Accept ([redacted] - 07/16/2025)***

Immediately the care staff removed all of the items in resident room #416.
Environmental rounds were started the next day 6/13/2025, by the director of environmental services, checking the room daily for poisonous materials.
For a period of 2 months, starting 6/14, room #416, will be checked daily for poisonous materials to ensure nothing poisonous is in the room by the director of environmental services or designee.
All staff education occurred 6/26/2025, conducted by the executive director, to alert team members that poisonous materials may not be in a resident's room at any time.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented ([redacted] - 08/07/2025)

95 - Furniture and Equipment

3. Requirements

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

Description of Violation

On 6/12/25, a green upholstered chair was observed in resident room #101. The arms of the char are heavily soiled with a dark black/brown substance that appears to be dirt.

Plan of Correction ***Accept ([redacted] - 07/16/2025)***

Immediately, the director of environmental services attempted to clean the chair. The chair is not dirty, but worn from decades of use.
As the item is a family heirloom, and in attempts to preserve the item and to respect resident and family wishes, coverings were placed over the dark areas on 7/1/2025 by the director of environmental services.
Beginning 7/1/2025, the director of environmental services will check the chair once a month for a period of three months to ensure the coverings are intact.
By 8/1/2025, the director of environmental services will be educated to the specifics of this regulation by the executive director, making the director of environmental services aware of what to look for in the community.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented ([redacted] - 08/07/2025)

103f - Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

103f - Refrigerator/Freezer Temps *(continued)*

Description of Violation

On 6/12/25, at 2:55 PM, the temperature in the freezer located in the 100-hall freezer was 10 degrees Fahrenheit, and at 5:04 PM, it was 18 degrees Fahrenheit.

On 6/12/25, at 3:25 PM, there was no thermometer in the freezer located in the 300-hall.

Plan of Correction ***Accept (- 07/16/2025)***

Immediately, the 300 hall thermometer was replaced by the director of culinary services.
Beginning 7/1/2025 the director of culinary services began daily environmental rounds to check the freezers in each neighborhood. The rounds include checking to ensure that the freezers have thermometers, and that the temperature reading is 0 degrees or below.
Environmental rounds will be conducted for a period of two months by the director of culinary services or designee to ensure compliance.
Culinary staff education will be conducted by 8/1/2025 to ensure all culinary staff are in compliance with this regulation. This will be conducted by the director of culinary services or designee.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 08/07/2025)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #5's initial medical evaluation, dated did not indicate if the resident was able to self-administer medications.

Plan of Correction ***Accept (- 07/16/2025)***

Immediately, the director of health and wellness was able to connect with the primary physician and correct the DME to note that the resident cannot self administer medications.
By 8/1/2025, an audit on all current residents DMEs, will be conducted by the director of health and wellness to ensure that all boxes relating to residents ability to administer medications are completed appropriately.
Education will be provided to the director of health and wellness by the executive director regarding proper DME documentation by 8/1/2025
For a period of 3 months, starting 7/1/2025, all new DMEs will be reviewed by the health and wellness director and

141a 1-10 Medical Evaluation Information (continued)

executive director to ensure completion.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 08/08/2025)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #4's annual medical evaluation, dated , did not include the resident's blood pressure, temperature, health status, and cognitive functioning.

Plan of Correction ***Accept (- 07/16/2025)***

Immediately, the director of health and wellness was able to connect with the primary physician for the resident, and have the boxes filled in on the DME.
By 8/1/2025, the director of health and wellness, or designee, will conduct an audit of all DME's for current residents to ensure the forms are completed.
For a period of 3 months, starting 8/1/2025, the executive director and health and wellness director will review all new resident DMEs to ensure completion.
Education will be provided to the director of health and wellness by the executive director regarding proper DME documentation by 8/1/2025

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 08/08/2025)

183d - Prescription Current

7. Requirements

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

Description of Violation

On 6/12/25, Miconazole cream 2% prescribed for resident #4 was in the home's medication cart. However, this cream was discontinued on 6/4/25.

Plan of Correction ***Accept (- 07/16/2025)***

Immediately, this medication was removed from the medication cart by the health and wellness director.
An audit will be conducted by the health and wellness director or designee for all medication carts by 8/1/2025 to ensure no expired medications are in the carts.
For a period of 3 months, a monthly cart audit will be conducted by the director of health and wellness or designee, to ensure no expired prescriptions are in the medication carts.
Education will be provided to the medication associates and nurses by director of health and wellness regarding medication storage by 8/1.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 08/07/2025)

185a - Implement Storage Procedures

8. 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 6/12/25, the following discrepancies were observed between the blood sugar readings in resident #6's glucometer and the documented blood sugar readings on resident #6's medication administration record (MAR):

- *On 6/3/25, at 5:43 PM, the resident's glucometer had a blood sugar reading of 194. However, there was no blood sugar reading documented on the resident's MAR.*
- *On 6/6/25, at 8:25 AM, the resident's glucometer had a blood sugar reading of 275. However, the blood sugar reading documented on the resident's MAR was 271.*
- *On 6/8/25, at 8:35 AM, the resident's glucometer had a blood sugar reading of 179. However, the blood sugar reading documented on the resident's MAR was 174.*
- *On 6/11/25, the resident's MAR had the following documented blood sugar readings: 313 at 8:15 AM, 374 at 12:41 PM, 79 at 3:50 PM, and 313 at 6:42 PM. However, these documented readings were not on the resident's glucometer.*

Repeated Violation - 7/9/24, et al

Plan of Correction ***Accept ([redacted] - 07/14/2025)***

Immediately, the Director of health and wellness audited resident 6s glucometer readings to ensure all readings were logged and accurate.
Beginning 6/13/2025 the Director of health and wellness or designee will audit resident 6's blood sugar readings weekly for 3 months to ensure that the blood sugar readings are logged in the glucometer and to check for transcription accuracy.
By 8/1/2025 all Med Techs and LPN's will receive education on proper blood sugar reading and documentation. Education will be conducted by the health and wellness director.

Proposed Overall Completion Date: 09/13/2025

Licensee's Proposed Overall Completion Date: *08/15/2025*

Implemented ([redacted] - 08/07/2025)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident #2 has prescribed daily weight measurements. However, on the 6/11/25, the resident was not weighed.

On 6/9/25, during nighttime medication administration, resident #4 was not administered the following medications:

- *Acetamin 325mg tablet with orders to take 2 tablets orally in the morning and at bedtime for pain.*
- *Brimonidine Sol 0.2% eyedrops with orders to instill 1 drop into each eye twice daily for glaucoma.*
- *Donepezil 5mg tablet with orders to take 1 tablet orally at bedtime for dementia.*

187d - Follow Prescriber's Orders (continued)

- *Dorzol/Timol Sol 2-0.5% eye drops with orders to instill 1 drop into each eye every 12 hours for glaucoma.*
- *Latanoprost SOL 0.005% eye drops with orders to instill 1 drop into each eye at bedtime for glaucoma.*

Repeated Violation - 7/9/24, et al

Plan of Correction ***Accept (- 07/14/2025)***

Immediately education was provided by the health and wellness director on proper medication administration to the medication associate on duty on 6/9/2025.
Beginning on 6/13/2025, for a period of 3 months, the director of health and wellness or designee will pull the medication pass report daily, to ensure all medications were administered for each shift.
By 8/1/2025, all medication associates and LPNs will receive additional education on proper medication documentation and procedures.

Proposed Overall Completion Date: 09/13/2025

Licensee's Proposed Overall Completion Date: *08/15/2025*

Implemented (- 08/07/2025)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #4's current medical evaluation, dated , indicates the resident has a need for mechanical soft foods. However, the resident's current assessment, dated states the resident is on a regular diet.

Plan of Correction ***Accept (- 07/16/2025)***

Immediately the director of health and wellness verified the correct diet designation.
On 7/7 the residents support plan was updated to update the correct diet by the director of health and wellness.
By 8/1, the director of health and wellness will complete an audit of all current DME's and RASPS to ensure the correct diets for residents are reflected on the RASP to match the DME
For a period of three months, the health and wellness director will monitor Resident #4's diet orders to ensure there are no further changes, and if there are diet changes, they will be reflected on the resident's support plan.
Health and Wellness director or designee will complete a quarterly audit of Current Rasps and Dme's to ensure diet designations match the DME and support plan. The quarterly audits will be conducted for 1 year starting 8/1/2025
Education will be provided to the director of health and wellness by the executive director regarding proper DME and Rasp documentation by 8/1/2025

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (- 08/08/2025)

236 - Staff Training

11. Requirements

2600.

236 - Staff Training *(continued)*

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

Staff person C, hired on [redacted], works in the Secure Dementia Care Unit and only had 4.5 hours of training in dementia care during the 2024 training year.

Plan of Correction ***Accept ([redacted] - 07/16/2025)***

Addition trainings were conducted on 7/09/2025 by the director of community integration for staff person C. These trainings are 1.5 hours of dementia specific training.
By 8/1/2025, executive director or designee will audit the annual training plan to ensure the topics for 2025 are dementia specific enough to meet criteria. Adjustments will be made to the calendar by 8/31 by the executive director, and additional trainings will be conducted should the audit reveal there are dementia specific training needs.
By 8/1/2025, all staff education for 2024 will be audited by the director of business services to ensure all staff are in compliance.
Education provided by executive director to the director of business services regarding dementia training requirements by 8/1/2025

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented ([redacted] - 08/07/2025)