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

August 1, 2024

[REDACTED], ADMINISTRATOR
PROVIDENCE PLACE OF POTTSVILLE ASSOCIATES
[REDACTED]

RE: PROVIDENCE PLACE OF POTTSVILLE
2200 FIRST AVENUE
POTTSVILLE, PA, 17901
LICENSE/COC#: 20397

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2024, 06/18/2024, 06/24/2024, 06/25/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PROVIDENCE PLACE OF POTTSVILLE* **License #**: *20397* **License Expiration**: *12/05/2024*

Address: *2200 FIRST AVENUE, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *PROVIDENCE PLACE OF POTTSVILLE ASSOCIATES*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/14/2013* **Issued By**: *City of Pottsville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *160* **Waking Staff**: *120*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/26/2024*

Inspection Dates and Department Representative

05/21/2024 - On-Site:
06/18/2024 - Off-Site:
06/24/2024 - Off-Site:
06/25/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *192* **Residents Served**: *118*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *56* **Residents Served**: *39*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *118*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *42* **Have Physical Disability**: *0*

Inspections / Reviews

05/22/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/19/2024*

Inspections / Reviews *(continued)*

08/01/2024 - POC Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *08/01/2024*

Follow-Up Type: *Bypass Document Submission*

08/01/2024 - Bypass Document Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *08/01/2024*

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

Resident #1 bit Resident # 3 on the arm, leaving broken skin which required wound care. During this encounter Resident #3 slapped Resident #1 to get the other resident to stop biting.

Resident # 4 was transported to a medical appointment by Staff A, when Staff A incorrectly lowered the wheelchair ramp prior to pushing the resident in a wheelchair onto the ramp, causing them both to fall out of the back of the van. Resident # 4 landed on the ground with Staff A falling on top of the resident. Resident #4 sustained [redacted] The resident was admitted to the hospital and then discharged [redacted]. The Administrator and Staff D explained the trained process as the driver gets out of the van, makes the lift mechanism horizontal to the ground, returns to the van, moves the resident and wheelchair to the lift and then lowers the lift to the ground, all while the Resident Aide on the transport stands at the end of the ramp. The Department Representative examined the transportation van used to take Resident #4 that day. All safety equipment was in correct working condition, including the warning alarm that the lift was in the lowered position when the wheelchair was pushed toward the threshold of the van. Staff A was interviewed, and stated the steps were completed out of order, and Staff A was uncertain how the mix up happened, since the staff had completed many transports previously without incident. Staff C was the Resident Aide on the transport. Staff C was at the office door waiting for the resident instead of at the end of the ramp as a second set of eyes to assist in preventing an accident. The course of events in this accident shows the Staff A and Staff B were negligent in following the proper procedure when assisting a resident in a wheelchair out of the van.

Repeat Violation: 1/3/24 et al.

Plan of Correction ***Accept ([redacted] - 08/01/2024)***

Residents #3 and #1 are [redacted] and had adjoining rooms.. Resident #1 has diagnosis of [redacted]. ED sent resident #1 out to hospital for evaluation and treatment due to [redacted] decline. Resident #1 was determined to be beyond facility care level and placed where [redacted] needs could be met. Resident #3 safety was intact as resident #1 never returned.4/2/24
ED/DON held meeting to reeducate staff on responsibility to help driver/resident when assisting with appointments 5/9/24 (see attached) Maintenance Director did Bus Safety training with drivers so that everyone would understand the operation of the bus 4/29 & 4/30/24 (see attached) Maintenance Director added Caution sign- resident in wheel chair loads first unloads last by back/front door. (see attached) attached caution card to remote with zip tie- please be sure when lift is down no resident on bus (see attached) Braun Lift company installed an added hand rail belt. (see attached) caution tape added across lift inside bus (see attached) Training was also added to all drivers e-learning from Braun Ability, the maker of the lift, to do annually. (see attached) Lift Manuel is also on bus for drivers to reference when needed. See attached. Maintenance will conduct training annually.

Licensee's Proposed Overall Completion Date: *07/11/2024*

Implemented ([redacted] - 08/01/2024)

42c - Treatment of Residents

2. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident # 2 reported to staff on 4/15/24 the night time LPN was rude to the resident and pinched the residents cheeks together to try to pour medication in the residents mouth.

Plan of Correction ***Accept (- 08/01/2024)***

ED/DON held nursing meetings on 4/23/24 and 4/24/24 with all Medication Technicians/LPN's to reeducate on proper medication administration. and resident rights. (sign in sheets attached) ED scheduled mandatory inservice 5/9/24 with Ombudsman, going over Residents Rights and Sensitivity Training, (see attached). DON will continue to reiterate proper medication administration and resident rights during her monthly nursing meetings which are scheduled the first Tuesday/Wednesday of each month unless otherwise posted.

Licensee's Proposed Overall Completion Date: *07/11/2024*

Implemented (- 08/01/2024)