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

March 3, 2025

[redacted]
PROVIDENCE PLACE OF DOVER ASSOCIATES
[redacted]

RE: PROVIDENCE PLACE OF DOVER
3377 FOX RUN ROAD
DOVER, PA, 17315
LICENSE/COC#: 33696

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/14/2025 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: *PROVIDENCE PLACE OF DOVER* **License #**: *33696* **License Expiration**: *02/11/2025*

Address: *3377 FOX RUN ROAD, DOVER, PA 17315*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *PROVIDENCE PLACE OF DOVER ASSOCIATES*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *05/21/2010* **Issued By**: *Dover Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *151* **Waking Staff**: *113*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *01/14/2025*

Inspection Dates and Department Representative

01/14/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *190* **Residents Served**: *115*

Special Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *74* **Residents Served**: *35*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *115*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *36* **Have Physical Disability**: *0*

Inspections / Reviews

01/14/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/08/2025*

02/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/10/2025*

Inspections / Reviews *(continued)*

02/13/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/28/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/03/2025*

03/03/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/28/2025*

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

15a Resident abuse report

1. Requirements

2800.
15.a. The residence 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], at approximately 11:45AM, there was a physical altercation between Resident [redacted] and Resident [redacted] Resident [redacted] grabbed Resident [redacted] and proceeded to push [redacted] against the wall. However, this allegation of abuse was never reported to the Local Area Agency on Aging.

On [redacted], at 9:18PM, when Staff Person A was exiting the Secure Dementia Care Unit (SDCU), Resident [redacted] approached Staff Person A and asked for help. Staff Person A then stated to Resident [redacted], "Don't [redacted] touch me, or I'll beat your [redacted]" and left the SDCU. This incident was witnessed by Staff Person B and Staff Person C. However, this allegation of abuse was not reported to the Local Area Agency on Aging until [redacted] at 1:50PM.

Plan of Correction ***Accept [redacted] - 02/13/2025)***

On 1/30 & 1/31/2025, the Executive Director, Director of Nursing, and Connections Director held an in-service on reporting suspected abuse. Staff was in-serviced to report suspected abuse immediately, per regulations. Initial report will be submitted followed up by final report after investigation is completed. Verbal reported to AAA by Executive Director on 12/1/2024 @ 1:45pm. Written report submitted to AAA by Executive Director on 2/13/25 @ 9:30 am. On-going monitoring of reviewing incident reports by ED, DON, an CN Director are being reviewed daily and will continue indefinitely.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Implemented [redacted] - 03/03/2025)

16c Incident reporting

2. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], at approximately 11:45AM, there was a physical altercation between Resident [redacted] and [redacted] where Resident [redacted] grabbed Resident [redacted] and proceeded to push [redacted] against the wall. However, this allegation of abuse was never reported to the Department.

On [redacted], at 9:18PM, when Staff Person A was exiting the Secure Dementia Care Unit (SDCU), Resident [redacted] approached Staff Person A and asked for help. Staff Person A then stated to Resident [redacted] "Don't [redacted] touch me, or I'll beat your [redacted]" and left the SDCU. This incident was witnessed by Staff Person B and Staff Person C. However, this allegation of abuse was not reported to the Department until 01/02/2025 at 2:00PM.

Plan of Correction ***Accept [redacted] - 02/13/2025)***

On 1/30 & 1/31/2025, the Executive Director, Director of Nursing, and Connections Director held an in-service on

16c Incident reporting (continued)

reporting suspected abuse. Staff was in-serviced to report suspected abuse immediately, per regulations. Initial report will be submitted followed up by final report after investigation is completed. Written report submitted to DHS by Executive Director on 2/13/25 @ 9:30 am. On-going monitoring of reviewing incident reports by ED, DON, an CN Director are being reviewed daily and will continue indefinitely.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Implemented [redacted] 03/03/2025)

42b Abuse/Neglect

3. Requirements

2800.
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 11:30AM, Resident [redacted] was attempting to enter [redacted] room. Resident [redacted] was in a confused state and thought that the room belonging to Resident [redacted] was Resident [redacted] room. Resident [redacted] then proceeded to grab both of Resident [redacted] forearms and prevented Resident [redacted] from entering [redacted] room. As a result of the incident, Resident [redacted] sustained four skin tears on [redacted] left forearm and one skin tear on [redacted] right forearm.

On [redacted], at approximately 9:30AM, Resident [redacted] was attempting to leave [redacted] room. Resident [redacted] was in a confused state and believed that Resident [redacted] was "breaking into" Resident [redacted] room. Resident [redacted] then proceeded to push Resident [redacted] causing Resident [redacted] to lose [redacted] balance and fall to the ground. As a result of the incident, Resident [redacted] had pain in [redacted] lower back and was sent to the emergency department for evaluation.

On [redacted] at approximately 3:30PM, there was a verbal altercation between Resident [redacted] and Resident [redacted]. Both residents were in the hallway outside of the wellness office and staff heard the residents arguing. When staff approached the residents to intervene, staff witnessed Resident [redacted] punch Resident [redacted] in the chest. Staff immediately separated the residents and assessed for injuries.

On [redacted], at approximately 11:45AM, Resident [redacted] was in a confused state and attempting to enter Resident [redacted] room. Resident [redacted] was informing Resident [redacted] that this was not Resident [redacted] room and asked Resident [redacted] to leave. Then Resident [redacted] grabbed Resident [redacted] and pushed Resident [redacted] into a wall.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] - 02/13/2025)***

The Business office manager, Connections Director, and Director of Nursing held mandatory in-services with staff on abuse and neglect on 1/2/25 and 1/3/2025. Residence will continue with new hire/onboarding and current staff annually to educate staff on abuse and neglect. Residence will increase additional abuse/neglect training throughout the year with Positive Approach to
Care (PAC) presented by Connections Director. The training will be held (in person) to ensure all staff receive this training annually. Next scheduled training will be held February 18 & 20, 2025 Quality management meetings will review trainings and any incidents identified. Resident # [redacted] support plan was updated on
11/4/2024 for proper support in areas of aggression towards others as well as supervision needs. Resident #1 was

42b Abuse/Neglect (continued)

given a 30 day discharge notice on 11/20/2024 and was discharged from facility on 12/20/2024. Staff will encourage/support residents to utilize life stations and participate in activity programs to help to prevent future resident to resident abuse. On-going RLA/MT's will continue daily to monitor resident behaviors and intervene when appropriate.

Proposed Overall Completion Date: 02/20/2025
Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Implemented (- 03/03/2025)

42c Dignity/Respect

4. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On , at 9:18PM, when Staff Person A was exiting the Secure Dementia Care Unit (SDCU), Resident approached Staff Person A and asked for help. Staff Person A then stated to Resident "Don't touch me, or I'll beat your " and left the SDCU. This incident was witnessed by Staff Person B and Staff Person C. Staff Person A was terminated as a result of the incident.

Plan of Correction ***Accept (- 02/13/2025)***

The Business office manager, Connections Director, and Director of Nursing held mandatory in-services with staff on abuse and neglect on 1/2/25 and 1/3/2025. Residence will continue with new hire/onboarding and current staff annually to educate staff on abuse and neglect. Residence will increase additional abuse/neglect training throughout the year with Positive Approach to
Care (PAC) presented by Connections Director. The training will be held (in person) to ensure all staff receive this training annually. Next scheduled training will be held February 18 & 20, 2025. Quality management meetings will review trainings and any incidents identified. Staff person A was suspended immediately on and employment was terminated . Daily monitoring by RLA/MT is in place to ensure residents feel safe and are treated with respect. Annual surveys to residents and family members are in place. Resident annual/ significant change support plan meetings are in place for resident and family members. The support plans are being reviewed by CN Director and or DON.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Implemented (03/03/2025)