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

May 29, 2025

[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 02/19/2025, 02/25/2025 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 POTTSVILLE* **License #**: *20397* **License Expiration**: *12/05/2025*

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

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

Administrator

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

Legal Entity

Name: *PROVIDENCE PLACE OF POTTSVILLE ASSOCIATES*

Address: [redacted]

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

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**: *188* **Waking Staff**: *141*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *03/25/2025*

Inspection Dates and Department Representative

02/19/2025 - On-Site: [redacted]

02/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *192* **Residents Served**: *128*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *unit* **Capacity**: *54* **Residents Served**: *42*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *154*

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

Have Mobility Need: *60* **Have Physical Disability**: *0*

Inspections / Reviews

02/19/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/27/2025*

03/27/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/11/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/03/2025*

Inspections / Reviews *(continued)*

04/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/11/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/11/2025*

05/29/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/11/2025*

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

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 2-19-2025 during initial walk through, a container full of empty pill packets with resident names and medications was found on top of the medication cart in the hallway near room 313.

On 2-19-2025, during initial walk though, it was observed that the home's licensing inspection summary dated 3-12-2024 was posted in a conspicuous area with the privacy coding document still attached.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Pill packets were immediately removed 2-19-25. ED ordered small trash cans and put on med carts for LPN/MT to put pill packets in. (see attached picture) DON will do random checks to ensure follow through.
Privacy coding document was removed immediately. 2-19-25 ED will be responsible for making sure that all licensing inspection summaries privacy coding documents will be removed before hanging them on bulletin board. 3-27-25 DON will do weekly checks during [redacted] rounds of the building.

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented ([redacted] - 05/29/2025)

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

On 2-19-2025, the contract for Resident 2 was not signed by the resident. Resident 2 moved into the secured dementia unit on [redacted]

On 2-19-2025, the contract for Resident 3 was not signed by the resident. Resident 2 moved into the secured dementia unit on [redacted]

Repeat Violation: 1-3-2024 et al.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Connections Director called family of resident 3 explaining the need to have resident signature on amendment or opportunity to sign when transitioning to Memory Care. Connections Director then went to resident 3 to get signature which was signed and dated 3/24/25. ED will audit all Connections resident charts to monitor for continued compliance ongoing.
Resident # 2 is PC resident and has never resided in secured neighborhood.
3/27/25-Audit of Connections resident charts will be completed by 4/4/25.

Licensee's Proposed Overall Completion Date: *04/04/2025*

25b - Contract Signatures *(continued)*

Implemented ([redacted] - 05/29/2025)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On 2-25-2025 at approximately 3:00p.m., the ice cream chest freezer had various flavors of ice cream that had been spilled all over the bottom and sides of the chest freezer.

Plan of Correction ***Accept ([redacted] - 03/27/2025)***

Director of Dining had freezer cleaned immediately. Director of Dining will check weekly x 4 weeks and then monthly x 2. Audit form attached and picture of clean freezer.

Licensee's Proposed Overall Completion Date: *03/24/2025*

Implemented ([redacted] - 05/29/2025)

101j7 - Lighting/Operable Lamp

4. 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

On 2-25-2025 at approximately 11:30a.m, Room 111 had a lamp on a table approximately 3 feet away from the foot of the bed and unable to be reached from the bedside.

Repeat violation: 1-3-2024 et al.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Connections Director immediately placed touch lite on wall bedside in room 111. Connections Director educated [redacted] regarding removing touch lite. Connections Director and Housekeeping Director educated staff in both departments. Connections Director has daily walkthrough audit to monitor for compliance ongoing. 3/27/25-Housekeeping/Nursing staff educated 2/26/25

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented ([redacted] - 05/29/2025)

103e - Left Overs

5. Requirements

2600.

103e - Left Overs *(continued)*

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 2-19-2025, during initial walk through, a baggie of blueberries and a container of chicken salad were found in the refrigerator in the 3rd floor dining area that were not labeled and dated.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Food was immediately removed. Dining Director provided labels for staff to label and date food and drinks. DON/Connections Director reeducated staff on labeling and dating food. (see attached sign in sheet) DON/ED will do random checks on going for compliance.

Proposed Overall Completion Date: 03/24/2025

3/27/25 staff reeducated on 2/26/25. Also see attached completed audit form for 3x weekly for 3 weeks. (starting 2/20 ending 3-19) checks.

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented ([redacted] - 05/29/2025)

103f - Refrigerator/Freezer Temps

6. 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.

Description of Violation

On 2-19-2025, during initial walk through, the freezer in the 3rd floor dining area did not have a thermometer.

On 2-25-2025 at approximately 3pm, the kitchen's ice cream chest freezer did not have a thermometer.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Dining Director purchased and placed in the two freezers thermometers. Dining Director will audit weekly x4 monthly x 2 for compliance. Attached are pictures of 3rd floor kitchen (ECN) freezer and Kitchen freezer, and Audit for dining director to complete.
ED will do random walk throughs to monitor compliance ongoing.
3/27/25 Thermometers were purchased and placed 2/26/25. See attached completed audit form 3x weekly for 3 weeks (starting 2/20 ending 3-19) checks.

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented ([redacted] - 05/29/2025)

103g - Storing Food

7. Requirements

2600.

103g - Storing Food *(continued)*

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 2-19-2025, during initial walk through, 2 bags of chips were located underneath the steam table in the 3rd floor dining room. The chips were not securely closed.

Repeat Violation: 1-3-2024 et al.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Chips were immediately removed. Dining Director provided labels for staff to label and date food and drinks. DON/Connections Director reeducated staff on labeling and dating food. DON/ED will do random checks on going for compliance. Attached education and labels.
3/27/25- 2/19 chips were immediately removed and labels were provided to staff. 2/26/25 DON/Connections Directors education was done with staff regarding food storage, labeling and dating food. Also see attached audit for completed random checks 3x week for 3 weeks. (starting 2/20 ending 3-19)

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented ([redacted] - 05/29/2025)

105g - Lint Removal and Duct Cleaning

8. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 2-19-2025, during initial walk through, an accumulation of lint was observed in the lint trap of the empty dryer located in the resident laundry room near room 217.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Lint was immediately removed. All staff re-educated on the removal of lint from dryers when doing laundry. Magnets purchased and placed on dryers stating remove lint. Housekeeping will continue to monitor for compliance ongoing. picture of magnet attached.
3/27/25 Staff to be educated on 2600.105.g during ED meetings 3/31/25 and 4/3/25. See attached agenda. Housekeeping will audit all laundry room dryers weekly x 4 weeks starting 3/28 ending 4/18. Attached

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented ([redacted] - 05/29/2025)

121a - Unobstructed Egress

9. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 2-19-2025, during initial walk through, in Connections Terrace, across from stairway A-T, the emergency exit was blocked from the outside by a large clump of rock salt and unable to be opened.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept (- 04/04/2025)***

Maintenance Director immediately removed the rock salt. Maintenance will check all egress when salting to make sure that the doors are free from any debris ongoing.
3/27/25- ED educated maintenance regarding reg 121a. 3/27/25 .

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented (- 05/29/2025)

131f - Fire Extinguisher Inspection

10. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 2-19-2025, during initial walk through, all of the home's fire extinguishers' tickets are punched with an expiration date of 1 year from January 2024.

Plan of Correction ***Accept (- 04/04/2025)***

Maintenance Director called [redacted] immediately and they came out 2/26/25 and corrected their mistake by retagging all extinguisher's with the correct tags. Attached is the documentation from [redacted] and the new tag photo.
Maintenance Director will monitor ongoing.
3/27/25 Maintenance Director will walk through building with [redacted] during annual inspection making sure tags are correctly marked before putting on the extinguishers.

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented (- 05/29/2025)

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

On 2-19-2025, Resident 1's annual medical evaluation that was completed on [redacted] was incomplete. The medication section indicated "see attached" but no documentation was attached.

Plan of Correction ***Accept (- 04/04/2025)***

Med sheet was immediately attached for resident 1. ED re-educated DON/Connections Director on the timeline of dates, admission paper work needed and care plans. ED will audit five charts monthly x 2 months.
3/27/25-ED corrected the date on education as it had been dated 2/26/24. It now correctly states 2/26/25. ED will audit 5 charts biweekly x 2 months.

Licensee's Proposed Overall Completion Date: *05/28/2025*

Implemented (- 05/29/2025)

162c - Menus Posted

12. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 2-19-2025, during initial walk through, the home did not have posted in a public and conspicuous area the home's menu for the current week and upcoming week in the Secured Dementia Unit. A posting for 1 week was posted in the Secured Dementia kitchenette, but the residents did not have access to this menu.

Plan of Correction ***Accept (- 04/04/2025)***

Two week menus were immediately hung. Dining Director will hang two week menus. Connections Director will audit this monthly x 3. Attached are the Audit Form and the menus. Menus were hung in the hall way on the bulletin board so all residents have access.
3/27/25 -ED educated Dining director for 162.c. 3/27/25.

Licensee's Proposed Overall Completion Date: *03/27/2025*

Implemented (- 05/29/2025)

183e - Storing Medications

13. 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 2-25-2025 at approximately 2:30p.m, Resident 6's medication of Metoprolol was still on the medication cart after being discontinued on 2-21-2025

Plan of Correction ***Accept (- 04/04/2025)***

Discontinued medication was removed immediately. LPN's/MT will make sure all discontinued medications are removed from cart immediately when discontinued. DON will do weekly Audit x 4 weeks to monitor for compliance. ED will do random checks to make sure compliance is ongoing. DON is implementing new order checklist during Nursing meetings 4/8 & 4/10 attached.
3/27/25 ED will do weekly check x 2 months.

Licensee's Proposed Overall Completion Date: *05/27/2025*

Implemented (- 05/29/2025)

185a - Implement Storage Procedures

14. 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 2-25-2025 at approximately 3:00p.m., Resident 7's PRN order of Deep Sea Saline Spray was not available.

185a - Implement Storage Procedures (continued)

Repeat Violation: 1-3-2024 et al.

Plan of Correction ***Accept (- 04/04/2025)***

DON immediately ordered Deep Sea Saline Spray for resident 7. It was received from pharmacy and is in cart. DON has weekly Med Cart Audits assigned to staff in electronic MAR for ongoing compliance.
3/27/25 Medication was received 2/25/25. See attached picture. DON will reeducate LPN's/MT on 185.a during nursing meetings on 4/8 and 4/10/25.

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Licensee's Proposed Overall Completion Date: *04/10/2025*

Implemented (- 05/29/2025)

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 1-14-2025, Resident 2 received another resident's dose of Zolpidem ER 12.5g instead of Resident 2's Clorazepate 3.75mg. The resident's MAR was not documented with the medication error.

Plan of Correction ***Accept (- 04/04/2025)***

DON will educate all LPN's/MT of this during monthly Nursing meetings to be held 4/8/25 and 4/10/25. Moving forward this will be standard practice for med error. DON will random audit ongoing for compliance.
3/27/25- DON will do random checks biweekly x 2 months. MAR updated 3/4/25.

Licensee's Proposed Overall Completion Date: *05/28/2025*

Implemented (- 05/29/2025)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

On 1-14-2025, Resident 2 received another resident's dose of Zolpidem ER 12.5g instead of their prescribed Clorazepate.

Repeat Violation: 1-3-2024 et al, & 1-6-2025.

Plan of Correction ***Accept (- 04/04/2025)***

DON re-educated MT on the five rights of med administration. DON counseled MT on the importance of focusing on passing medications and not becoming distracted. DON observed MT do med pass and will continue to monitor MT ongoing for compliance.

187d - Follow Prescriber's Orders (continued)

3/27/25 DON did reeducation with MT 1/17/25. DON monitored med passes 1/19/25, 1/23/25 and 1/25/25 .

Licensee's Proposed Overall Completion Date: *03/28/2025*

Implemented (- 05/29/2025)

224a - Preadmission Screen Form

18. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 2 was admitted to the home on ; but no preadmission screening form was completed as of 2-19-2025.

Plan of Correction ***Accept (- 04/04/2025)***

ED spoke to DON, Connections Director, Sales Director regarding the need for a preadmission screen for each resident. ED will monitor charts ongoing for compliance.
3/28/25 Sales found original Preadmission screen. in computer file.
ED/DON Connections Director will audit all resident files by 4/4/25 for preadmission screen form.
ED will audit all resident charts upon admission for preadmission form for continued compliance.

Licensee's Proposed Overall Completion Date: *04/04/2025*

Implemented (- 05/29/2025)

227g -Support Plan Signatures

19. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

On 2-19-2025, the Resident Assessment Support Plan for Resident 8, dated 2-4-2025, and for Resident 3, dated 1-1-2025, were not signed by the residents. There was no notation that the residents did not want to participate or was unable to sign.

On 2-19-2025, Resident 9's Resident Assessment Support Plan dated 6-29-2024 was not signed by the resident. The home wrote N/A on the signature field of the RASP but did not indicate the resident refused or was unable to sign.

On 2-19-2025, Resident 4's Assessment Support Plan dated 9-20-2024 was not signed. The home did not indicate if the resident refused or was unable to sign.

Plan of Correction ***Accept (- 04/04/2025)***

ED re-educated DON/Connections Director regarding the need for residents signatures or opportunity to sign.
Attached is resident #8, #9 and #4 signature page of support plan. ED will monitor five charts monthly x 2 months.
3/28/25-Rasps were signed by residents 2/25/25. ED/DON/Connections Director will complete audit of all charts

227g -Support Plan Signatures (continued)

for RASP signatures by 4/4/25.

Licensee's Proposed Overall Completion Date: *04/04/2025*

Implemented (- 05/29/2025)

231b - Medical Evaluation

20. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit on [redacted] but did not have a medical evaluation completed until [redacted].

Plan of Correction ***Accept (- 04/04/2025)***

Resident 1 passed way [redacted] ED re-educated DON/Connections Director on the timeline of dates, admission paper work needed and care plans. ED will audit five charts monthly x 2 months for ongoing compliance..
3/28/25- 2/26/25 ED reeducated DON/Connections Director.

Licensee's Proposed Overall Completion Date: *03/28/2025*

Implemented (- 05/29/2025)

231e - No Objection Statement

21. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 1 was admitted to the secure dementia unit of the home on [redacted] There was not a non-objection statement in the resident record from the resident or their designee.

Plan of Correction ***Accept (- 04/04/2025)***

Resident #1 passed away on [redacted] Attached is the amendment signed by [redacted] agreeing to the move on [redacted] to Connections memory support. [redacted] was notified of move and was only able to come in to sign on [redacted]
Going forward ED will monitor Connections Charts for compliance of signatures of residents.
3/27/28 ED/Connections Director will monitor all charts for non-objection statement by 4/4/2025. ED will review all new admission charts for statement.

Licensee's Proposed Overall Completion Date: *04/04/2025*

Implemented (- 05/29/2025)

231g - Non-Dementia Admission

22. Requirements

2600.

231g - Non-Dementia Admission *(continued)*

231.g. An individual who does not have a primary diagnosis of Alzheimer's disease or other dementia may reside in the secured dementia care unit if desired by the resident.

Description of Violation

On [redacted], Resident 8 moved into Secured Dementia Unit, without a diagnosis of Dementia, to reside [redacted]. During an interview with Resident 8 on 2-19-2025, the resident indicated they were unable to use the codes to exit the unit. The resident stated they were not trained how to use the codes or where to find them. Resident 8 stated that they could only leave the unit when family came to visit.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Resident 8 resides in PC part of facility. ED reached out to home office and has attached form that we will use going forward for any PC resident living on secured unit. ED educated DON/Connections Director to include on support plan that they have been taught code and how to get in/out of unit. ED will audit five charts monthly x 2 months for ongoing compliance.
3/27/25-On [redacted] when Resident 8 moved into Connections [redacted] was educated by staff regarding the code and how to enter/exit neighborhood. 2/26/25 ED educated DON/Connections Director regarding code and regulations. .

Licensee's Proposed Overall Completion Date: *03/28/2025*

Implemented ([redacted] - 05/29/2025)

234d - Support Plan Revision

23. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

On 2-19-2025 the Resident Assessment and Support Plan dated, [redacted] indicated Resident 1 was minimally mobile. Interviews with Staff person B revealed that hospice changed resident to totally immobile and staff are not to take resident out of bed due to the high fall risk.

Plan of Correction ***Accept ([redacted] - 04/04/2025)***

Resident 1 passed away [redacted]. Director ED re-educated DON/Connections Director on care plan changes, timelines, admission paperwork. ED will audit five charts monthly x 2 months for ongoing compliance.
3/28/25-ED educated DON/Connections Director 2/26/25. ED will audit five charts bi-weekly x 2 months for compliance.

Licensee's Proposed Overall Completion Date: *05/28/2025*

Implemented ([redacted] - 05/29/2025)