

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

March 12, 2026

[REDACTED], EXECUTIVE DIRECTOR
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 01/06/2026, 01/07/2026 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: PROVIDENCE PLACE OF POTTSVILLE License #: 20397 License Expiration: 12/05/2026
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: 186 Waking Staff: 140

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Incident Exit Conference Date: 01/07/2026

Inspection Dates and Department Representative

01/06/2026 - On-Site: [REDACTED]
01/07/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	192	Residents Served:	122
Secured Dementia Care Unit			
In Home:	Yes	Area:	N/A
Capacity:	54	Residents Served:	37
Hospice			
Current Residents:	18		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	122
Diagnosed with Mental Illness:	5	Diagnosed with Intellectual Disability:	1
Have Mobility Need:	64	Have Physical Disability:	0

Inspections / Reviews

01/06/2026 - Full
Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/08/2026

03/03/2026 - POC Submission
Submitted By: [REDACTED] Date Submitted: 03/04/2026
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 03/05/2026

Inspections / Reviews *(continued)*

03/12/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/04/2026

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

85d - Trash Receptacles

1. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/6/26 at 3:40 p.m., 3 large trash cans in the kitchen were not covered with lids and no lids were located near the trash cans.

Plan of Correction

Accept () - 03/03/2026

Lids were immediately replaced on trash cans. Executive Chef to do training with staff on keeping lids in place and perform audits to assure lids are in place when not in use. Executive Chef to audit for compliance 3x week x 2 weeks, 2x week x 1 week then 1 x week x 1 week beginning 2/2/2026 ending week of 2/23/2026 Executive Chef to monitor as needed for ongoing compliance

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026

103f - Refrigerator/Freezer Temps

2. 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 1/6/26 at 9:40 a.m., the refrigerator in the third-floor activities room did not contain a thermometer.

Repeated violation 2/19/25 et al.

Plan of Correction

Accept () - 03/03/2026

Thermometer immediately placed in refrigerator by Maintenance Director. Maintenance Director to perform audits beginning week of 2/2/2026 3 x week x 2 weeks, then 2 x a week x 1 week then 1 x a week x1 week. Club Coordinator to monitor as needed for compliance

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026

103g - Storing Food

3. Requirements

2600.

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

Description of Violation

On 1/6/26 at 3:45 p.m., the kitchen's main freezer contained an open and unsealed clear plastic bag of hamburger patties.

Repeated violation 4/23/25, 2/19/25 et al.

Plan of Correction

Accept () - 03/03/2026

Hamburger patties immediately removed from freezer and disposed of. Dining Director to hold training with

103g - Storing Food (continued)

kitchen staff of proper storage and labeling of food. Audits to be completed for compliance by Dining Director. Audits to be completed beginning week of 2/2/2026 3 x week x 1 week then 2 x week x 2 week then 1 x week x 1 week. Ongoing monitoring to be completed as needed by Dining Director for compliance.

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 1/6/26 at 3:50 p.m., two dented 104 oz cans of Sisko Fancy Sauerkraut were in the dry food storage of the kitchen.

Plan of Correction

Accept () - 03/03/2026

Dented cans were immediately removed from storage and disposed of. Executive Chef to do training with staff on disposal of dented cans when delivered from supplier. Audits to be completed 2 x a week times 4 weeks then as needed for compliance. Audits to begin week of 2/2/2026

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026

125a - Combustible Storage

5. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 1/6/25 at approximately 10:00 a.m. a tissue was found approximately 2 inches from the dryer hose in the Memory Care laundry room.

Plan of Correction

Accept () - 03/03/2026

Tissue was immediately removed from area. Training to be completed by CN Director with staff on checking around and behind dryer after each use. Beginning week of 2/2/2026 audits to be completed on CN dryer 3x weekly x 2 weeks then 2x weekly x 1 week then 1 x week x 1 week. CN Director to monitor for compliance as needed

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026

141b1 - Annual Medical Evaluation

6. Requirements

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

141b1 - Annual Medical Evaluation (continued)

Description of Violation

Resident #1's medical evaluation dated [REDACTED], the section noting ability to self-administer medications was not completed.

Repeated violation 2/19/25 et al.

Plan of Correction

Accept ([REDACTED]) - 03/03/2026

DME fixed immediately. Executive Director did verbal training with DON stating that all DMEs need to be reviewed by DON and then again by ED prior to being placed in chart. DON to completed audits to assure all DMEs are completed in full. Audits to be done on 2 residents 3x weekly x 1 week then 2x weekly x 2 weeks then 1 x week x 1 week beginning week of 2/2/2026. ED and DON to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented ([REDACTED]) - 03/12/2026

183b - Meds and Syringes Locked

7. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 1/6/26 at 9:49 a.m. on the 2nd floor Secured Dementia Care Unit there was a container of Minerine Crème 1lb. stored on a table located outside of room [REDACTED]. The medication was prescribed to Resident #2.

Plan of Correction

Accept ([REDACTED]) - 03/03/2026

Cream was immediately removed from hallway and placed in locked med cart. CN Director to complete training during her monthly staff meeting on proper storage of medications/creams in memory care units. CN Director to complete audits to assure medications/creams are locked up after each use. Audits to be done on 2 residents 3x weekly x 1 week then 2x weekly x 2 weeks then 1 x week x 1 week beginning week of 2/2/2026 DON and CN Director to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented ([REDACTED]) - 03/12/2026

184a - Resident's Meds Labeled

8. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

On 1/7/26, Resident #1 had a doctors' order to check fasting blood sugar in the morning and a PRN order to check fasting blood sugar if need. The medication pharmacy label reads: check fasting blood sugar daily in the morning and it does not mention PRN fasting as needed.

Plan of Correction

Accept ([REDACTED]) - 03/03/2026

Change of direction label immediately placed on box on lancets. CN Director and/or DON to do training with Nurse/medication technicians on use of medication label change stickers. Audits to be done on 2 residents 3x

184a - Resident's Meds Labeled (continued)

weekly x 1 week then 2x weekly x 2 weeks then 1 x week x 1 week beginning week of 2/2/2026. DON and CN Director to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026

187a - Medication Record

9. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

On 1/7/26 Resident #1's medication administration record states PRN Loperamide 2mg, give 2 tablets initially, then 1 tablet by mouth as needed for each subsequent loose stools: Do not exceed 16gm in 24 hours. The doctors order states Imodium 2mg 1 tab by mouth after each loose stool as needed for diarrhea, not to exceed 8mg (4tabs) in 24 hours.

Resident #3 is prescribed a PRN order for Diclofenac Sodium 1% Gel. On 1/7/26, the resident's January 2026 medication record did not list the medication.

Plan of Correction

Accept () - 03/03/2026

CN Director faxed signed order to pharmacy to have directions changed on MAR to match signed order. Signed order for Resident #3 immediately found and faxed to pharmacy to be added to MAR. CN Director and DON to have training with nurses and medication technicians on checking to see if medication is listed on MAR and that the directions match prior to placing medications in cart. Audits to be done on 2 different med carts per week until all med carts are completed. Beginning week of 2/2/2026. DON and CN to monitor for compliance as needed

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026

233c - Key-Locking Devices

10. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 1/6/25 at approximately 9:45 a.m. the directions for operating the home's locking mechanism were not conspicuously posted near the either of the 2 gates found in the courtyard of the Secure Dementia Care Unit (SDCU).

Plan of Correction

Accept () - 03/03/2026

Maintenance Director immediately placed codes on both gates. Audits to be completed to assure codes remain in place by Maintenance Director beginning week of 2/2/2026 3 x week x 2 weeks then 2 x week x 1 week then 1 x week x 1 week. Maintenance Director to monitor as needed for ongoing compliance.

Licensee's Proposed Overall Completion Date: 02/28/2026

Implemented () - 03/12/2026