Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

May 8, 2026

HERITAGE MILLS PERSONAL CARE CENTER LLC
C/O ISLE HEALTHCARE

RE: HERITAGE MILLS PERSONAL CARE CENTER
846 EAST WICONISCO AVENUE
TOWER CITY, PA, 17980
LICENSE/COC#: 22636

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/13/2026 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,

Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HERITAGE MILLS PERSONAL CARE CENTER* **License #**: *22636* **License Expiration**: *09/04/2026*

Address: *846 EAST WICONISCO AVENUE, TOWER CITY, PA 17980*

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

Administrator

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

Legal Entity

Name: *HERITAGE MILLS PERSONAL CARE CENTER LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *03/28/2012* **Issued By**: *Borough of Tower City*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *69* **Waking Staff**: *52*

Inspection Information

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

Reason: *Complaint, Fine* **Exit Conference Date**: *03/13/2026*

Inspection Dates and Department Representative

03/13/2026 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *43*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *30* **Residents Served**: *23*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

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

Have Mobility Need: *26* **Have Physical Disability**: *0*

Inspections / Reviews

03/13/2026 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/13/2026*

04/21/2026 - POC Submission

Submitted By: **Date Submitted**: *05/02/2026*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/01/2026*

Inspections / Reviews *(continued)*

05/08/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/02/2026*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident is prescribed , one tablet twice daily. On the home was informed by the resident's family member that resident had not received their 8:00 p.m. administration of this medication since . The medication was not administered at 8:00 p.m. until Also, on staff person A was notified via text that the resident's 8:00 p.m. prescribed dose of was not available in the medication cart to administer. The home did not report the medication errors to the department's regional office.

Resident is prescribed tablet to be administered twice daily; however, the medication was not available in the medication cart for administration on at 8:00 a.m. and 8:00 p.m. In addition, resident is prescribed tablet to be administered three times daily. On and at 8:00 a.m., 2:00 p.m. and 8:00 p.m., and on at 2:00 p.m. the medication was not available in the medication cart for administration. The home did not report the medication errors to the department's regional office.

Resident is prescribed to be administered at bedtime; however, on and , the medication was not available in the medication cart for administration. Resident is also prescribed tablet to be administered once per day, however, on the medication was not available in the medication cart for administration. Resident is prescribed tablet to be administered 4 times daily; however, on at 12:00 p.m. and 8:00 p.m. the medication was not available in the medication cart. The home did not report the medication errors to the department's regional office.

Resident has an order for and is to be administered 1 tablet at bedtime. On at 8:00 p.m. the medication was not administered due to not being available in the medication cart. Resident has also an order for which is to be applied topically in the morning and at bedtime. On at 8:00 a.m., the cream was not administered due to not being available in the medication cart. The home did not report the medication errors to department's regional office.

Plan of Correction ***Accept - 04/21/2026)***

1. The facility cannot retroactovely correct the medications that were not available. On 3/13/26 the Administartor/designee ensured that Resident and s medications were availble as prescribed by the physician.

2. The administrator/designee will complete and audit of current resident's physician orders and the medication carts on the 1st and 2nd floor. Findings related to medications not available and missed medications will be reported to the physican and the department. This will be completed by 3/27/26.

3. The administrator/designee will complete education to the nursing staff on the importance of monitoring medication availability and the need to report medication errors within 24 hrs to the physician and the department. This will be completed by 3/27/26

16c Written Incident Report (continued)

4. The administrator/designee wil perform an audit of medication availability for administration for 5 random residents 2x a week for 4 weeks and monthly x 2 months. Med errors identified will corrected immediately and reported to the physican and the department within 24 hours. The weekly audits will begin on 4/3/26 and findings will be documented and reviewed for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 05/08/2026)

187a - Medication Record

2. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

Description of Violation

Resident [redacted] is prescribed [redacted], one tablet twice daily. From [redacted] when the resident was admitted to the home until [redacted] the order for the medication was listed on the Medication Administration Record (MAR) as one tablet daily.

Resident [redacted] is prescribed [redacted], one tablet daily at night. From [redacted] to [redacted] the medication was not included on the MAR.

Resident [redacted] is prescribed [redacted], two sprays in each nostril once daily. The order for the [redacted] spray was not included on the MAR for March 2026.

Plan of Correction ***Accept [redacted] - 04/21/2026)***

1. The facility cannot retroactively correct the missed medication times and the medications not on the MAR to be given. on 03/13/2026 by the Administrator/designee updated Resident [redacted] s medication frequency for Memantine HCl 10mg was updated, Donepezil 10 mg & Fluiticasone was verified with the physician and added to the MAR.
2. The administrator/designee will complete an audit of any new admissions starting 3/27/26 reviewing the current medication list they were admitted with is inputted into the system with the correct frequency and added to the MAR for administrations. Any findings will be addressed and updated correctly in the medication system.
3. The administrator/designee will complete education training to nursing staff on the importance of reviewing the current medication list of residents admitted to the facility prior to medication administration to ensure the correct medication are in the system with the correct frequency. This will be completed by 3/27/26.

187a - Medication Record (continued)

4. The administrator/designee of new admission medications within 24 hrs and current resident new physician orders within 24 hrs to ensure physicians orders were entered correctly int he medication system and on the MAR for administartion. The audit will be completed weekly x 4 weeks and monthly x 2 months. Any concerns identified will be corrected immediately. The weekly audits will begin on 4/3/26 any findings will be reviewed for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented - 05/08/2026)

187c - Refusal of Medication

3. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On at 8:00 p.m., Resident refused to take a scheduled does of and the facility did not notify the resident's prescriber or physician.

Plan of Correction ***Accept 04/21/2026)***

1. The facility cannot retroactively correct not notifying the physician of Resdient refusal of medication. On 3/13/26 the facility will monitor resident for any further refusals and update the physican as needed.
2. The administrator/designee will complete an audit of all current residents for refusals and update the physician. The audit will be completed by 3/27/26.
3. The administrator/designee will complete education to the nursing staff on the importance of reporting residents medication refusals daily, so they can be reported to the physician timely. This will be completed by 3/27/26.
4. The administrator/designee will perform an audit of resident refusals weekly x 4 weeks and then monthly x 2 months. Any concernes identified will be reported and corrected immediately. The weekly audits will begin on 4/3/26 any findings will be reviewed for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented - 05/08/2026)

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

Resident is prescribed , one tablet twice daily. The medication was only administered daily at 8:00 a.m. from through

187d Follow Prescriber's Orders (continued)

Resident is prescribed , one tablet orally at night. The medication was not administered from through

Resident is prescribed , one tablet twice daily, hold for Systolic Blood Pressure (SBP) less than On resident SBP was but the medication was still administered. Resident is prescribed 1 capsule twice daily and , take one twice daily. On the medications were not administered at 8:00 a.m. because the medications were not available in the home.

Resident is prescribed one tablet daily. On the medication was not administered at 8:00 a.m. because the medication was not available in the home. Resident is prescribed , one tablet in the morning and one tablet in the evening. On the medication was not administered at 5:00 p.m. because the medication was not available in the home.

Resident is prescribed , one tablet daily. On the medication was not administered at 8:00 a.m. because the medication was not available in the home. Resident also prescribed eyelid wipes to be used as directed in the morning. On the eyelid wipes were not administered at 8:00 a.m. because the wipes were not available in the home.

Resident has an order for tablet to be administered 3 times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m. On and the medication was not administered due to the medication not being available on the medication cart. On the medication was not administered at 2:00 p.m. because it was not available in the medication cart.

Resident was prescribed tablet from to to be administered 1 tablet twice daily at 8:00 a.m. and 8:00 p.m. On the medication was not administered due to the medication not being available on the medication cart.

Resident has an order for and is to be administered 35 units under the skin 3 times a day at 8:00 a.m., 12:00 p.m., and 5:00 p.m. plus sliding scale with a hold for blood glucose under 90 and a half dose (17 units) with a blood glucose under 110. On and the amount of medication administered to the resident is not recorded on the medication administration record. On at 12:00 p.m., the resident's blood glucose level was and of the medication were administered instead of the 17 units as ordered by the prescriber.

Resident has an order for tablet to be administered once daily at 8:00 p.m. On , the medication was not administered due to the medication not being available on the medication cart.

Resident was prescribed and 17 grams to be administered at 8:00 p.m. On and the medication was not administered due to the medication not being available on the medication cart.

Resident has an order for tablet and is to be administered 4 times daily at 8:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. On the medication was not administered at 12:00 p.m. and 8:00 p.m. due to the medication not being available in the medication cart.

Resident has an order for and is to be administered 1 tablet at bedtime. On at 8:00 p.m. the medication was not administered due to not being available in the medication cart.

187d - Follow Prescriber's Orders (continued)

Resident [redacted] has an order for [redacted] which is to be applied topically in the morning and at bedtime. On [redacted] at 8:00 a.m., the cream was not administered due to not being available in the medication cart.

Resident [redacted] has an order for [redacted] and ½ tablet is to be administered daily; with a hold on administration if the SBP (systolic number/top number) is less than [redacted] OR if heart rate is less than 60. The resident's medication administration record for March 2026 does not record resident heart rate. There is no documentation that the resident's heart rate was taken prior to administration of medication from [redacted] to [redacted] per the prescriber's orders.

Plan of Correction ***Accept [redacted] - 04/21/2026)***

The facility cannot retroactovely correct the medications that were not available, amount units given of insulin, and heart rate documentation. On 3/13/26 the Administartor/designee ensured that Resident [redacted] and [redacted] medications were availble as prescribed by the physician. Resident [redacted] physician was updated on the incorrect units of insulin given and Resient [redacted] order was reviewed with staff to ensure they were documenting the heart rate prior to administering the medication.

2. The administrator/designee will complete and audit of current resident's physician orders and the medication carts on the 1st and 2nd floor. Findings related medications not available and missed medications will be reported to the physican and the department. An audit of current residents receiving insulin will be completed for correct units given. Findings will be reported to the physician as needed. An audit of current residents with hear rate monitoring prior to med adminsitration will be completed for heart rate documentation prior to med administration. Findings will be reported to the physician as needed. This will be completed by 3/27/26.

3. The administrator/designee will complete education to the nursing staff on the importance of monitoring medication availability and the importance of updating the physician when the medication is not available and taking and documenting the heart rate per physicians orders piror to med adminsitration. A diabetic training class will be held on 4/10/26 to review obtaining glucose readings, and review of insulin units to be given. This will be completed by 4/10/26

4. The administrator/designee wil perform an audit of medication availability for administration, correct insulin units given, and heart rate documentation prior med administration for 5 random residents 2x a week for 4 weeks and monthly x 2 months. Any concerns identified will be reported and corrected immediately . The weekly audits will begin on 4/3/26 and findings will be documented and reviewed for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 05/08/2026)

188b - Medication Error Reporting

5. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

188b - Medication Error Reporting *(continued)*

Description of Violation

Resident [redacted] is prescribed [redacted], one tablet twice daily. On [redacted] the home was informed by the resident's family member that resident [redacted] had not received their 8:00 p.m. administration of this medication since [redacted] The medication was not administered at 8:00 p.m. until [redacted] Also, on [redacted] staff person A was notified via text that the resident's 8:00 p.m. prescribed dose of [redacted] was not available in the medication cart to administer. The home did not report the medication errors to the prescriber.

Resident [redacted] has an order for [redacted] tablet to be administered 3 times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m. On [redacted] and [redacted] the medication was not administered due to the medication not being available on the medication cart. On [redacted] the medication was not administered at 2:00 p.m. because it was not available in the medication cart. The home did not report the medication errors to the prescriber.

Resident [redacted] was prescribed [redacted] tablet from [redacted] to [redacted] to be administered 1 tablet twice daily at 8:00 a.m. and 8:00 p.m. On [redacted] the medication was not administered due to the medication not being available on the medication cart. The home did not report the medication errors to the prescriber.

Resident [redacted] has an order for [redacted] tablet to be administered once daily at 8:00 p.m. On [redacted], the medication was not administered due to the medication not being available on the medication cart. The home did not report the medication error to the prescriber.

Resident [redacted] was prescribed [redacted] and 17 grams to be administered at 8:00 p.m. On [redacted] and [redacted] the medication was not administered due to the medication not being available on the medication cart. The home did not report the medication errors to the prescriber.

Resident [redacted] has an order for [redacted] and is to be administered 4 times daily at 8:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. On [redacted] the medication was not administered at 12:00 p.m. and 8:00 p.m. due to the medication not being available in the medication cart. The home did not report the medication errors to the prescriber.

Resident [redacted] has an order for [redacted] and is to be administered 1 tablet at bedtime. On [redacted] at 8:00 p.m. the medication was not administered due to the medication not being available in the medication cart.

Resident [redacted] has also an order for [redacted] which is to be applied topically in the morning and at bedtime. On [redacted] at 8:00 a.m., the cream was not administered due to the medication not being available in the medication cart. The home did not report the medication errors to the prescriber.

Plan of Correction ***Accept [redacted] - 04/21/2026)***

1. On 3/13/26 the Administartor/designee reported the medication errors to the physicians for Resident [redacted] and [redacted]
2. On 3/16/26 the administrator/designee will complete and audit of current resident's for any medication errors. Findings will be reported to the residents physician.

188b - Medication Error Reporting (continued)

3. The administrator/designee will complete education to the nursing staff on the importance of monitoring medication availability and the need to report medication errors to the physician. This will be completed by 3/27/26.
4. The administrator/designee wil perform an audit of medication errors for 5 random residents 2x a week for 4 weeks and monthly x 2 months. Med errors identified will corrected immediately and reported to the physician. The weekly audits will begin on 4/3/26 and findings will be documented and reviewed for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented - 05/08/2026)

225a - Assessment 15 Days

6. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident s initial assessment dated did not include an update regarding a change in the resident's presence in the home. When resident was admitted to the home on it was noted on the assessment that the resident's family member would pick the resident up daily at 5:00 p.m. and the resident would spend weekday evenings and weekends at home with the family member. On the family member notified the home that resident would be staying in the home full time. The home did not update the assessment regarding the change in resident living arrangements and the change in the resident's medication administration needs.

Plan of Correction ***Accept - 04/21/2026)***

1. Resident assessment was updated to reflect permanent status at the facility by 3/16/26.
2. The administrator/designee beginning 3/16/26 will review new admissions in morning meeting to ensure the residents assessment is completed within 15 days and added to the residents record.
3. The administrator/designee will educate administrative staff assisting with completing the resident assessments within 15 days of admission. This will be completed by 3/27/26.
4. The administrator/designee will complete an audit of new admissions for completion of resident assessments within 15 days of admission weekly x 4 weeks and monthly x 2 months. Any concerns identified will be reported and corrected immediately . The weekly audits will begin on 4/3/26 and findings will be documented and reviewed for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented - 05/08/2026)