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

June 16, 2026

[redacted]
PROVIDENCE PLACE OF COLLEGEVILLE ASSOCIATES
[redacted]

RE: PROVIDENCE PLACE AT THE
COLLEGEVILLE INN
4000 RIDGE PIKE
COLLEGEVILLE, PA, 19426
LICENSE/COC#: 14477

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/30/2026 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 AT THE COLLEGEVILLE INN* **License #**: *14477* **License Expiration**: *09/12/2026*

Address: *4000 RIDGE PIKE, COLLEGEVILLE, PA 19426*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *PROVIDENCE PLACE OF COLLEGEVILLE ASSOCIATES*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/02/2020* **Issued By**: *Lower Providence Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *166* **Waking Staff**: *125*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *04/30/2026*

Inspection Dates and Department Representative

04/30/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *115*

Special Care Unit

In Residence: *Yes* **Area**: *1st Floor Main* **Capacity**: *47* **Residents Served**: *32*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *115*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *51*

Have Physical Disability: *0*

Inspections / Reviews

04/30/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/28/2026*

06/03/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/11/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/15/2026*

Inspections / Reviews *(continued)*

06/16/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/11/2026*

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 residence 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, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], The residence received a complaint alleging possible abuse or neglect of a resident. On [redacted]. The residence received an additional complaint alleging possible abuse or neglect of the same resident. This allegation of abuse or neglect was not reported to the local Area Agency on Aging.

Plan of Correction ***Accept ([redacted] - 06/03/2026)***

- On 4/30/26 the Executive Director shared with the DHS licensing representative that a complaint was received on 4/11/26 regarding a concern that Resident [redacted]s [redacted] had on 4/10/26. The concern on 4/7/26 was regarding who the staff person was in the room that they saw on [redacted] mother's camera. At the request of resident [redacted]s [redacted] community complied immediately and assigned another resident life associate to resident [redacted] Staff person A worked 4/11/26 and 4/13/26 and were given other assignments. [redacted] concern on 4/10/26 was regarding resident [redacted]s toileting needs overnight. As the Executive Director and Connections Director investigated the situation, they chose to put Staff person A out on leave pending an investigation on 4/14/26 considering the recent request of the family to move [redacted] off [redacted] mother's assignment.~~ Executive Director shared internal investigation reports with DHS licensing representative to prove that care had been provided by a different resident life associate that was assigned to [redacted] Resident [redacted] has no skin breakdown, health concerns or signs or symptoms of pain or discomfort throughout any specified shifts. Additionally, [redacted] RASP states that [redacted] requires total assistance from our staff to assist [redacted] with [redacted] toileting care with a daily/PRN time requirement. [redacted] does not have specific times assigned to [redacted] care tasks. Due to the outcome of this internal investigation, the community did not deem this a case of abuse/neglect and therefore did not need to report to the local Area Agency on Aging.~~

-On 5/18/26 the Executive Director, Connections Director and Director of Nursing received education on 15a by reviewing the Violations Report and Regulatory Compliance Guide.

-On 5/18/26 the Director of Nursing & Connections Director reviewed the last month of reportable incidents and determined that no other incidents fell into the category of 15a.

Starting 5/2026 or once plan of correction is accepted, this will be reviewed monthly for a total of three months by our Management Team for ongoing compliance and discussed during quarterly quality assurance meetings.

Proposed Overall Completion Date: 05/31/2026

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented [redacted] - 06/16/2026)

15c Supervision plan submission

2. Requirements

15c Supervision plan submission *(continued)*

2800.
15.c. The residence shall immediately submit to the Department's assisted living residence office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted], The residence received a complaint alleging possible abuse or neglect of a resident by Staff person A. On [redacted] The residence received an additional complaint alleging possible abuse or neglect of the same resident by the same staff person. The staff person was not initially suspended until [redacted]. Staff person A returned to work without an approved plan of supervision developed in conjunction with the Department on [redacted]

Plan of Correction ***Accept [redacted] - 06/03/2026)***

-On 4/30/26 the Executive Director shared with the DHS licensing representative that a complaint was received on 4/11/26 regarding a concern that Resident [redacted]s [redacted] had on 4/10/26. The concern on 4/7/26 was regarding who the staff person was in the room that they saw on [redacted] mother's camera. At the request of resident [redacted]s [redacted] community complied immediately and assigned another resident life associate to resident [redacted] Staff person A worked 4/11/26 and 4/13/26 and were given other assignments. [redacted] concern on 4/10/26 was regarding resident [redacted]s toileting needs overnight. As the Executive Director and Connections Director investigated the situation, they chose to put Staff person A out on leave pending an investigation on 4/14/26 considering the recent request of the family to move [redacted] off [redacted] mother's assignment. ~~Executive Director shared internal investigation reports with DHS licensing representative to prove that care had been provided by a different resident life associate that was assigned to [redacted] Resident [redacted] has no skin breakdown, health concerns or signs or symptoms of pain or discomfort throughout any specified shifts. Additionally, [redacted] RASP states that [redacted] requires total assistance from our staff to assist [redacted] with [redacted] toileting care with a daily/PRN time requirement. [redacted] does not have specific times assigned to [redacted] care tasks. Due to the outcome of this internal investigation, the community did not deem this a case of abuse/neglect and therefore felt that staff member A could return and from a customer service prospective the community made the decision to continue to have [redacted] assist on a different assignment other than resident [redacted] Considering this was not a case of abuse and neglect the community would not have to submit a plan of supervision to the Department.~~

-On 5/18/26 Executive Director received training about regulation 15c from the Violation Report and Regulatory Compliance Guide.

-Starting 5/2026 or once plan of correction is accepted, this will be reviewed monthly for a total of three months by our Management Team for ongoing compliance and discussed during quarterly quality assurance meetings

Proposed Overall Completion Date: 05/31/2026

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented [redacted] - 06/16/2026)

16c Incident reporting

3. Requirements

2800.

16c Incident reporting *(continued)*

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], Resident [redacted] experienced change in health condition and was transported to the hospital for treatment. The resident returned to the home on [redacted] The residence did not report the incident to the Department until [redacted].

Plan of Correction ***Directed [redacted] - 06/03/2026)***

On 4/30/26 the DHS licensing representative educated the Executive Director, Connections Director and Director of Nursing that Resident [redacted] the seizure activity would fall into the incident reporting category of reportable incidents. Resident [redacted] does not have chronic seizure activity, is not on medication for seizure and this was an isolated incident. ~~A 'change in health condition' as the Department has listed it on the violation report is not a category under the reportable incidents within the Regulatory Compliance Guide.~~

On 4/30/26 Director of Nursing and/or designee spoke with the Nursing team to educate them on seizures falling into 16c incident reporting.

On 5/1/26 Connections Director and Director of Nursing reviewed their resident incidents for the last month to ensure that no other residents had seizures or changes in health conditions.

Starting 5/2026 or once plan of correction is accepted, this will be reviewed monthly for a total of three months by our Management Team for ongoing compliance and discussed during quarterly quality assurance meetings.

Directed

In addition to the above plan of correction *The Administrator, Connections Director, and Director of Nursing will review the RCG Appendix B as it refers to reportable incidents.[redacted]*

Proposed Overall Completion Date: 05/31/2026

Directed Completion Date: *05/31/2026*

Implemented [redacted] - 06/16/2026)

23a ADL assistance

4. Requirements

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted] for resident [redacted] indicates the resident requires assistance with toileting, including bladder and bowel management. On several occasions including [redacted] and [redacted] the resident did not receive this assistance as required during the overnight shifts.

23a ADL assistance *(continued)*

Plan of Correction ***Directed [redacted] - 06/03/2026)***

On 4/30/26 the Executive Director shared with the DHS licensing representative that a complaint was received on 4/11/26 regarding a concern that Resident [redacted]s [redacted] had on 4/10/26. The concern on 4/7/26 was regarding who the staff person was in the room that they saw on [redacted] mother's camera. [redacted] concern on 4/10/26 was regarding resident [redacted]s toileting needs overnight. ~~Executive Director shared internal investigation reports with DHS licensing representative to prove that care had been provided by the resident life associate that was assigned to [redacted] Resident [redacted] has no skin breakdown or health concerns that negatively impacted [redacted] overall wellbeing. Additionally, [redacted] RASP states that [redacted] requires total assistance from our staff to assist [redacted] with [redacted] toileting care with a daily/PRN time requirement. [redacted] does not have specific times assigned to [redacted] care tasks. Additionally, there was never any communication during the complaint or inspection that there was an issue on 4/4/26 and 4/9/26. The complaint was received about 4/10/26.~~

On 5/15/26 Connections Director and/or designee educated the Nursing, Med Tech and RLA team on the importance of documentation and 23a.

On 5/1/26 5/8/26 The Nursing Coordinator audited all the care tasks within the EMAR system to ensure they matched the needs of the residents.

Starting 5/2026 or once plan of correction is accepted, this will be reviewed monthly for a total of three months by our Management Team for ongoing compliance and discussed during quarterly quality assurance meetings.

Proposed Overall Completion Date: 05/31/2026

Directed

In addition to the above plan of correction *All direct care staff will be re educated on instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan by 6/15/26.* [redacted]

Directed Completion Date: *06/15/2026*

Implemented [redacted] - 06/16/2026)

42b Abuse/Neglect

5. 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

Resident [redacted] support plan, dated [redacted] indicates the resident requires total assistance with toileting, including bladder and bowel management. During the night of [redacted] resident [redacted] did not receive staff assistance with incontinence care for bowel and bladder management between 9:00 p.m. and 4:00 a.m. Additionally, on the morning of [redacted] resident [redacted] was soaked at the beginning of the next shift. The residence's internal investigation documented that staff person B provided care to resident [redacted] during the 10:00 p.m. to 6:00 a.m. shift on [redacted]. It was determined that they did not actually provide care to resident [redacted] during that shift.

42b Abuse/Neglect (continued)

Plan of Correction ***Accept [redacted] 06/03/2026)***

On 4/30/26 the Executive Director shared with the DHS licensing representative that a complaint was received on 4/11/26 regarding a concern that Resident [redacted]s [redacted] had on 4/10/26. The concern on 4/7/26 was regarding who the staff person was in the room that they saw on [redacted] mother's camera. At the request of resident [redacted]s [redacted] community complied immediately and assigned another resident life associate to resident [redacted] Staff person A worked 4/11/26 and 4/13/26 and were given other assignments. [redacted] concern on 4/10/26 was regarding resident [redacted]s toileting needs overnight. As the Executive Director and Connections Director investigated the situation, they chose to put Staff person A out on leave pending an investigation on 4/14/26 considering the recent request of the family to move [redacted] off [redacted] mother's assignment. ~~Executive Director shared internal investigation reports with DHS licensing representative to prove that care had been provided by a different resident life associate that was assigned to [redacted] Resident [redacted] has no skin breakdown, health concerns or signs or symptoms of pain or discomfort throughout any specified shifts. Additionally, [redacted] RASP states that [redacted] requires total assistance from our staff to assist [redacted] with [redacted] toileting care with a daily/PRN time requirement. [redacted] does not have specific times assigned to [redacted] care tasks. Due to the outcome of this internal investigation, the community did not deem this a case of abuse/neglect~~

On 4/30/26 Connections Director and/or designee educated the Nursing, Med Tech and RLA team on 42b and communication expectations in accordance with Providence policies.

On 5/1/26 5/8/26 The Nursing Coordinator audited all the care tasks within the EMAR system to ensure they matched the needs of the residents.

On 4/30/26 and moving forward for the next month, the Team Lead/Med Tech in Connections are required to support the final rounds with the Resident Life Associates to spot check their work and ensure that all care was completed to the resident by the end of the shift.

Starting 5/2026 or once plan of correction is accepted, this will be reviewed monthly for a total of three months by our Management Team for ongoing compliance and discussed during quarterly quality assurance meetings.

Proposed Overall Completion Date: 05/31/2026

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented ([redacted] - 06/16/2026)

101j7 Lighting/operable lamp

6. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] 06/03/2026)***

On 4/30/26 the Maintenance Director was informed there was not a working bedside lamp within reach of the

101j7 Lighting/operable lamp (continued)

bed for Resident [redacted] While DHS licensing representative was standing by this was corrected on site. On this date the Executive Director ordered touch lights for each resident room to have on their nightstand or headboard.

-On 5/7/26 the Housekeeping Director and/or designee walked all resident rooms in assisted living and Connections (secured dementia unit) to secure the touch light within reach of the bed.

-On 5/7/26 the Housekeeping Director and/or designee educated the housekeepers on 101j7 and to be checking for functionality and presence during weekly housekeeping visits.

-On 5/7/26 Connections Director and/or designee informed [redacted] team of the update of the resident room check form stating that the light has now been replaced with a touch light.

Starting 5/2026 or once plan of correction is accepted, this will be reviewed monthly for a total of three months by our Management Team for ongoing compliance and discussed during quarterly quality assurance meetings.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented [redacted] - 06/16/2026)

187a Medication record

7. Requirements

2800.
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.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident [redacted] is prescribed [redacted] take 1 tablet once per day. Additional instructions on the medication label indicates that the medication should be given 30 to 60 minutes before eating, swallow whole, do not chew or crush. However, resident's [redacted] medication administration record does not include "take 30 to 60 minutes before eating".

187a Medication record *(continued)*

Plan of Correction ***Accept[redacted] - 06/03/2026)***

On 4/30/26 the Connections Director Nurse was informed that for Resident [redacted] The label on [redacted] medication and the MAR do not match. Resident [redacted] continues to use an outside pharmacy which has caused repeated concerns to the community. Community has suggested the in house primary pharmacy to help elevate such concerns and family of resident [redacted] does not want to change pharmacies.

On 5/5/26 the Connections Nurse obtained an updated order to ensure that the MAR and medication labels match. There was no ill effect on the residents and was assessed by the Connections Nurse.

On the Connections Director and/or designee provided education to all the nurses and med techs about 187a.

On 5/5/26 the Nursing Director and/or designee audited all the residents with an outside pharmacy to ensure that the labels and MAR match.

Starting 5/2026 or once plan of correction is accepted, this will be reviewed monthly for a total of three months by our Management Team for ongoing compliance and discussed during quarterly quality assurance meetings.

Licensee's Proposed Overall Completion Date: *05/31/2026*

Implemented [redacted] - 06/16/2026)