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

June 5, 2025

[redacted]
COLUMBIA COTTAGE-COLLEGEVILLE LLC
[redacted]

RE: COLUMBIA COTTAGE-
COLLEGEVILLE, LLC
901 E. MAIN STREET
COLLEGEVILLE, PA, 19426
LICENSE/COC#: 13892

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/31/2025, 04/01/2025 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: *COLUMBIA COTTAGE-COLLEGEVILLE, LLC* **License #**: *13892* **License Expiration**: *05/02/2025*

Address: *901 E. MAIN STREET, COLLEGEVILLE, PA 19426*

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

Administrator

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

Legal Entity

Name: *COLUMBIA COTTAGE-COLLEGEVILLE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/18/1997* **Issued By**: *COPA L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *43* **Waking Staff**: *32*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *04/01/2025*

Inspection Dates and Department Representative

03/31/2025 - On-Site: [redacted]

04/01/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *23*

Special Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *23*

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

Have Mobility Need: *20* **Have Physical Disability**: *2*

Inspections / Reviews

03/31/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/03/2025*

05/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/29/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/17/2025*

Inspections / Reviews *(continued)*

05/16/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/29/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/30/2025*

06/05/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/29/2025*

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 7:00 A.M., Staff Person A allegedly shoved a soapy rag into Resident [redacted]s mouth in retaliation for knocking their glasses off of their face. This incident was observed by Staff Person B. This incident was reported to Staff Person C on [redacted], at 1:50 P.M. However, this allegation of abuse was not reported to the local Area Agency on Aging until [redacted] at 12:15 P.M.

Plan of Correction ***Accept [redacted] - 05/12/2025)***

On 4/22/2025 and 4/23/2025, all staff were re-educated on the facility's abuse reporting policy by the Managing Director and designee. The in-service sign in sheet and supporting information is attached. A 'Report of Suspected Abuse' quick form has been created by the Managing Director and is accessible in the nurse's office. The policy for the form is as follows. If a staff person witnesses suspected abuse they will fill out the 'Report of Suspected Abuse' form and submit the report to their immediate supervisor. The supervisor will immediately report to the manager designee on call. The alleged perpetrator will be immediately suspended pending investigation by the designee. The designee will then complete all reporting requirements and initiate the abuse investigation. All new hires will continue to receive training on abuse recognition and reporting within 24 hours of hire and also be educated on the 'Report of Suspected Abuse' form and the policy that is in place. To ensure ongoing compliance, all current staff will complete a re-training course on abuse reporting every six months, beginning May 1, 2025 conducted by the Managing Director or designee. The Managing Director or designee will ensure compliance by reviewing training records quarterly, verifying staff participation, and ensuring that all reports of suspected abuse are documented, investigated, and followed up according to regulatory timeliness.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 06/05/2025)

15b Resident abuse-superv plan

2. Requirements

2800.
15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted] at 7:00 A.M., Staff Person A allegedly shoved a soapy rag in Resident #[redacted] mouth in retaliation for knocking their glasses off of their face. This incident was observed by Staff Person B and reported to Staff Person C on [redacted], at 1:50 P.M. Staff Person A continued to work on [redacted] from 6:30 A.M. until 3:00 P.M. and was not suspended until [redacted]. The residence conducted an investigation and brought Staff Member A back to work unsupervised on [redacted] prior to the Department conducting an abuse investigation.

Plan of Correction ***Accept [redacted] - 05/12/2025)***

On 4/25/2025, all supervisory and management staff were re-trained by the Managing Director on Columbia Cottage's suspected resident abuse reporting policy. The inservice included that pending an investigation an alleged perpetrator must be immediately suspended upon any allegation of abuse .

15b Resident abuse superv plan (continued)

Before a staff member returns to work, a plan of direct supervision must be developed and put in place. The plan will be developed the Managing Director or designee and approved by BSHL or AAA before the staff person returns to work. To ensure ongoing compliance Managing Director or designee will conduct quarterly audits to review all instances of abuse allegations to ensure that proper procedures were followed, including immediate suspension and approved supervision of the accused staff member. The first audit will be completed by May 15 by the Managing Director or designee and quarterly thereafter.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented ([redacted] - 06/05/2025)

16c Incident reporting

3. 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], Staff Member A allegedly shoved a soapy rag into Resident [redacted]'a mouth in retaliation for knocking of their glasses. The residence did not report this incident to the Department until [redacted].

Plan of Correction ***Accept [redacted] - 05/12/2025)***

The incident was reported to the Department on 3/21/2025 once the delay was recognized by the Managing Director. On 4/25/2025, all staff were re educated on the facility's abuse reporting policy by the Managing Director and designee. The in service sign in sheet and supporting information is attached . A 'Report of Suspected Abuse' quick form has been created by the Managing Director and is accessible in the nurse's office. The policy for the form is as follows. If a staff person witnesses suspected abuse they will fill out the 'Report of Suspected Abuse' form and submit the report to their immediate supervisor. The supervisor will immediately report to the manager designee on call. The alleged perpetrator will be immediately suspended pending investigation by the designee. The designee will then complete all reporting requirements and initiate the abuse investigation. All new hires will continue to receive training on abuse recognition and reporting within 24 hours of hire and also be educated on the 'Report of Suspected Abuse' form and the policy that is in place. To ensure ongoing compliance, all current staff will complete a re training course on abuse reporting every six months, beginning April 2025. The Managing Director or designee will ensure compliance by reviewing training records quarterly, verifying staff participation, and ensuring that all reports of suspected abuse are documented, investigated, and followed up according to regulatory timeliness.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 06/05/2025)

42b Abuse/Neglect

4. 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 7:00 A.M., staff Member A and B were providing assistance to Resident [redacted] while giving

42b Abuse/Neglect (continued)

them a bed bath. Resident [redacted] was laying in bed during care and requires the assistance of two persons with care tasks. Resident [redacted] knocked off Staff Member A's glasses prior to care starting and this staff member shoved a soapy rag in this resident's mouth. Staff Member B witnessed staff member A's behavior. Staff Member A reported this was a reflex and not intentional. Resident #[redacted] confirmed a staff member shoved a soapy rag in their mouth. Staff Member B stepped in and cleaned Resident #[redacted] face. Staff Member B told Resident [redacted] they were safe and continued with washing care. Staff Member A also assisted with care that was not facing Resident [redacted] Staff Member B removed the rag from the resident's mouth and continued care. Staff Member B then assisted in dressing Resident [redacted] However, staff member B placed the residents arms through the arms of the shirt but did not allow the resident's hands to pass through the buttoned cuff in order to restrict arm movement. According to the assessment and support plan dated 6/4/24 under aggression Resident [redacted] can be aggressive with care and the staff are to make this resident feel safe and re approach at a later time if combative.

Plan of Correction ***Accept [redacted] 05/12/2025)***

Staff Member A was immediately removed by the Managing Director from resident care duties pending internal investigation on March 28th, 2025. Resident [redacted] was assessed immediately for physical and emotional harm by the nursing staff and monitored per shift for three days to ensure wellbeing. Staff Member A was suspended for violating abuse policies by the Managing Director pending investigation. Staff Member B was re trained immediately by the Managing Director, with emphasis on re approach technique practices. Re training documentation is attached . All direct care staff received mandatory re education on abuse prevention, resident rights, proper techniques for handling aggressive behaviors, and reporting protocols for witnessed or suspected abuse. Training was completed on 4/25/2025 by the Managing Director and designee. To ensure ongoing compliance, resident interviews will be conducted monthly for the next three months by the Managing Director or designee. They will begin on May 15, 2025. These will ensure that the residents are feeling safe and being cared for with dignity. Any discrepancies will be investigated immediately by Managing Director or Designee.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 06/05/2025)

65h 16 hrs annual training

5. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person A received only 12 hours of annual training relating to [redacted] job duties during training year January 1, 2024 to December 31, 2024.

Direct care staff person B received only 12 hours of annual training relating to [redacted] job duties during training year January 1, 2024 to December 31, 2024.

Plan of Correction ***Accept ([redacted] 05/12/2025)***

Staff Member A separated from the organization prior to undergoing the planned re training session. Staff Member B will complete the remaining four hours of dementia specific required training by 5/16/2025. The titles of the courses of retraining are 'Dementia Training for Staff'. The Resident Services Director (RSD) will ensure that all monthly staff training is completed by the 5th of the month to follow. Any staff member who does not complete the monthly staff training by the deadline, will be suspended until the training is completed. To ensure ongoing compliance,

65h 16 hrs annual training (continued)

Managing Director or RSD will conduct monthly audits by the 5th of following month and contact staff who have not completed the training to have them complete the training promptly.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented ([redacted] - 06/05/2025)

65i Training topics

6. Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Assisted living service needs of the resident.

Description of Violation

Direct care staff person A did not receive training in the following topics:
1. Medication self administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Assisted living service needs of the resident.
during the training year January 1, 2024 to December 31, 2024.

Direct care staff person B did not receive training in the following topics:
1. Medication self administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Assisted living service needs of the resident.
during the training year January 1, 2024 to December 31, 2024.

Plan of Correction ***Accept ([redacted] - 05/12/2025)***

Staff Member A separated from the organization prior to undergoing the planned re training session. Staff Member B received training by the Resident Service Director on May 1, 2025 in medication self administration training, instruction on meeting the needs of the residents as described in the assessment tool, medical evaluation and support plan, and assisted living service needs of the resident. To ensure ongoing compliance, The Managing Director or designee will review the monthly training log to ensure that the staff are completing their required trainings on time. This review will occur monthly starting on May 1, 2025, and any discrepancies will be immediately addressed by the MD or RSD.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 06/05/2025)

65j Annual training content

7. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

65j Annual training content *(continued)*

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff Person A did not receive training in Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

Staff Person B did not receive training in Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

Plan of Correction ***Accept [redacted] - 05/16/2025)***

Staff Member A separated from the organization prior to undergoing the planned re-training session. Staff Member B was re-trained in fire safety by a certified fire safety expert on May 15, 2025. The annual training for the staff in fire safety will be conducted on August 7, 2025 by Harold Hicks, named 'Annual Fire Safety Inspection, Drill, and Training'. To ensure ongoing compliance, the Managing Director or designee will ensure that all staff will be present for the annual fire safety training by email and text reminders. If the staff person is not present for the training, the Managing Director will ensure that suitable annual fire safety training is completed with the training year for the staff person. This training will be documented by the Managing Director or designee.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Implemented [redacted] - 06/05/2025)

69 Dementia training

8. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person A, date of hire [redacted], received only 1 hour of [redacted]-specific training relating during training year January 1, 2024 to December 31, 2024.

Staff person B, date of hire [redacted], received only 1 hour of [redacted]-specific training relating during training year January 1, 2024 to December 31, 2024.

Plan of Correction ***Accept [redacted] - 05/12/2025)***

Staff Member A separated from the organization prior to undergoing the planned re-training session. Staff Member B was immediately scheduled by the Managing Director to complete an additional 1 hour of dementia-specific training. This training was done via online training and the course was called 'Dementia Training for Staff'. This training was completed on May 1, 2025. This training fulfills the required 2-hour minimum for the 2024 calendar year. To ensure ongoing compliance, The Managing Director or designee will review the monthly training log to ensure that the staff are completing their required trainings on time. This review will occur monthly starting on May 1, 2025, and any discrepancies will be immediately addressed by the MD or RSD.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 06/05/2025)

69 Dementia training *(continued)*

201 Positive interventions

9. Requirements

2800.
201. Safe Management Techniques - The re[redacted]e shall use positive interventions to modify or eliminate a behavior that endangers the resident [redacted] or others. Positive interventions include improving communications, reinforcing appropri[redacted]havior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident [redacted] is combative during care. The residence has not implemented positive interventions to modify or eliminate the behavior. On [redacted] staff person A continued providing care to Resident [redacted] after this resident knocked staff person's A's glasses off and kicked them multiple times. Resident [redacted] assessment and support plan dated [redacted] instructs staff to re-approach and make this resident feel safe when combative during care. Staff Person A continued to provide care and did not re-approach the resident on [redacted]

Plan of Correction ***Accept [redacted] 05/12/2025)***

Staff Member A was immediately removed from direct care duties and suspended by the Managing Director pending investigation. Staff Member A separated from the organization prior to undergoing the planned re-training session. Resident [redacted] was assessed by the nursing staff for physical and emotional well-being following the incident. The support plan was reviewed and updated by the Resident Service Director to reinforce the need for a re-approach protocol and clarify escalation warning signs. Ongoing behavioral tracking for Resident [redacted] has been initiated by the Resident Service Director to help identify patterns and triggers. All direct care staff received in-service training on person-centered behavioral interventions, positive behavior support and de-escalation techniques, and adhering to individualized support plans during care. Training was completed on April 18, 2025 by the Managing Director and RSD. To ensure ongoing compliance, this training will be conducted quarterly or more often if necessary by the Managing Director.

Licensee's Proposed Overall Completion Date: *05/09/2025*

Implemented [redacted] - 06/05/2025)

202 Prohibitions

10. Requirements

2800.
202. The following procedures are prohibited:
5. A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribe[redacted]by a medical professional as long as the resident can easily remove the device or the resident or [redacted] designee understands the need for the device and consents to its use.
6. A manual restraint, define[redacted]as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move [redacted] arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompti[redacted] escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On [redacted] at 7:00 A.M., Resident [redacted] was combative during care and trying to hit the staff. Staff person B put Resident [redacted] hands in their button up shirt sleeves but did not allow the resident's hands to go through the cuffs in

202 Prohibitions (continued)

order to restrict how far the resident could extend their arms.

Plan of Correction ***Accept (- 05/16/2025)***

Staff Member B received re training on prohibited interventions and resident rights on April 18, 2025 by Resident Service Director. All direct care and ancillary staff received training on the above topics on 'meeting the needs of the residents based on assessment' and 'understanding and upholding your residents' rights' by the Managing Director and RSD . This training was focused on prohibiting manual and mechanical restraints, appropriate behavior management alternatives, and resident rights during care. To ensure ongoing compliance, the Managing Director or designee will perform random observation checks during activities of daily living care sessions weekly for two months to ensure interventions remain compliant. These random checks will begin on May 5, 2025.

Licensee's Proposed Overall Completion Date: *05/18/2025*

Implemented - 06/05/2025)