Sent via e-mail [mlapinsky@traditionsofhershey.com]

MAILING DATE: March 9, 2020

Mr. Kevin McCollum
Its Manager
GAHC3 PALMYRA PA ALF TRS SUB LLC
18191 Von Karman Avenue, Suite 300
Irvine, California 92612

RE: Traditions of Hershey
100 North Larkspur Road
Palmyra, Pennsylvania 17078
Certificate #: 332600

Dear Mr. McCollum:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living) review on November 18, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

*Gloria Emick*

Gloria Emick
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

# Violation Report

## Facility Information

Name: *TRADITIONS OF HERSHEY* License Number: *33260*
Address: *100 NORTH LARKSPUR ROAD,, PALMYRA, PA 17078*
County: *LEBANON* Region: *CENTRAL*

## Administrator

Name: *Michale Lapinsky* Phone: *7178382330* Email: *mlapinsky@traditionsofhershey.com*

## Legal Entity

Name: *GAHC3 PALMYRA PA ALF TRS SUB LLC*
Address: *18191 VON KARMAN AVE,SUITE 300, IRVINE, CA, 92612*

## Certificate(s) of Occupancy

1/9/08, 12/3/12 Other, I-1 South Londerry Twp.

## Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *41* Waking Staff: *31*

## Inspection

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

## Inspection Dates and Department Representative

*11/18/2019 - On-Site: Kellie Cargile, Mike Showers*

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: *36* Residents Served: *33*

### Secured Dementia Care Unit

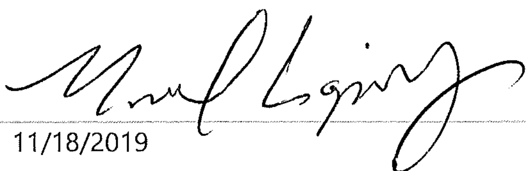
In Home: *No* Area: Capacity: Residents Served:

### Hospice

Current Residents: *0*

### Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *33*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *8* Have Physical Disability: *0*



Michael Lapinsky, Administrator 12/16/19

## 29a SOPb1- Hospice Care: Doctor Certification

### Regulations

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

### Description of Violation

Resident #1, who was not evacuated during the fire drills conducted on 5/28/19, 6/12/19, and 7/30/19, had a physician's order stating, "patient may remain in his room/apt during any fire drill." There was no written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

### Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

**What:** Resident #1 had an order to remain in room during evacuation, however the order not specifically state that evacuation could injure the resident or hasten his death. Resident #1 has since passed.
**Who:** The Resident Care Director or Designee will educate the team when to obtain specific orders pertaining to Hospice residents participation in fire drill evacuations. *(Attachment A.)* An audit will be completed of each hospice resident currently in house to determine if they meet the criteria to not participate in the evacuation. See *(Attachment B)*. For all residents that meet that criteria, proper orders will be maintained and available for the state to review.
**When:** The Resident Care Director or Designee will complete the Audit and train the team by January 1, 2020.
**How:** The Resident Care Director or Designee will obtain orders on all identified hospice residents.
**Ongoing:** The Resident Care Director or Designee will monitor as a resident's condition changes and a new order will be obtained as needed. Monthly audit of all hospice residents will be completed to ensure participation in fire drills or simulation occurs *(Attachment B)* and Fire Drill Worksheet *(Attachment C)*. All results will be reviewed in the quarterly QA meeting.

### Legal Entity Representative

Signature

Michael Lapinsky, Administrator — Printed Name and Title

12/16/19 — Date

### DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/6/20 (Date)

Plan of correction implementation status as of 3/6/20 (Date)

☒ Implemented

The above plan of correction was approved by GE (Initials)

☐ Not Implemented

## 29a SOPb5ii - Hospice Care: Fire Drill Simulation

### Regulations

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

5. If the provisions of paragraph (4) are initiated, the informed staff person is to immediately practice a fire drill evacuation in accordance with the following:
   - ii. Reasonably simulate the level of effort required to move the resident and proceed to practice evacuation to the nearest unblocked exit or fire safe area. The simulation will include the number of staff persons that is required during an evacuation to safely move the resident.

### Description of Violation

During the fire drills on 5/28/19, 6/1/19, and 7/30/19, staff did not reasonably simulate the effort required to move Resident #1 and proceed to practice evacuation to the nearest unblocked exit or fire safe area.

### Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

***What:*** Resident #1 was not evacuated for the fire drill. There was an order from the physician to keep the resident in their room during the drills. The order did not include the proper statement that evacuation could injure the resident or hasten their death.

**Who:** The Executive Director, Fire Safety Expert, Resident Care Director or Designee will utilize **(Attachment B and D)** to educate the Resident Care Department and track status of current Hospice residents and review orders monthly to note any changes. This document will be available during fire drills and resident room will have an identifying colored sticker to notify staff that resident is not to be evacuated and a simulation will take place.

**When:** Audit will be completed by January 1, 2020, sticker's will be in place and staff will be educated on the new process by January 15th, 2020. ***(Attachment B)***

**How:** Monthly audit of current Hospice resident roster

**Ongoing:** Hospice resident tracker will be cross-referenced with current active resident list with a monthly audit by Executive Director, Fire Safety Expert, Resident Care Director or Designee findings will be reviewed in the quarterly QA meeting.

### Legal Entity Representative

Signature

Michael Lapinsky, Administrator — Printed Name and Title

12/16/19 — Date

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## 107d - Procedure Emergency Management Agency Submission

### Regulations

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

### Description of Violation

The home's written emergency procedures were not submitted to the local emergency management agency for 2018.

### Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

***What:*** Identified during annual survey on 11/18/19 letter was not mailed to the local emergency management agency. The home shall mail a copy to the local EMA with the home's emergency procedures annually.
***Who:*** The Executive Director or Designee assures the emergency procedures will be mailed to the local EMA annually. The Executive Director or Designee will train the management team on Plan of Correction Training (Attachment E) and utilize the **Emergency Procedures audit tracker (Attachment F)** on an annual basis to ensure local emergency management agency has updated home emergency procedures.
***When:*** Emergency procedures mailed to local emergency management agency on 12/16/19 with cover letter.
**How:** Annual Audit by the Executive Director or Designee to ensure emergency procedures are mailed to local EMA
***Ongoing:*** The Executive Director or Designee will conduct annual audit (Attachment F) to ensure copy of home's emergency procedures are mailed to local EMA and findings will be reviewed in the quarterly QA meeting.

### Legal Entity Representative

[signature] Signature — Michael Lapinsky, Administrator — Printed Name and Title — 12/16/19 Date

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## 183e - Storing Medications

### Regulations

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

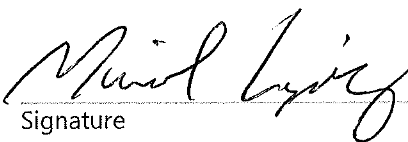
On 11/18/19, two loose pills were located in the home's medication cart.

### Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

**What:** On 11/18/19, surveyor observed 2 loose pills in the bottom of the cart during the annual survey. Immediately they were removed and properly destroyed.
***Who:*** Resident Care Director or Designee will train all Med Techs on Plan of Correction Training **(Attachment G)** and the Weekly Cart Audit Process **(Attachment H)** to ensure medication is stored properly by 1/1/20.
**When:** The Resident Care Director or Designee will begin weekly audits on 12/17/19 and will be ongoing **(Attachment H)**.
**How:** Resident Care Director or Designee will audit the medication card every Monday and any additional locked medication storage cabinets weekly to ensure all medications are stored properly and accounted for.
**Ongoing:** Medication cart will house routine medication be audited weekly. As needed medication will be stored in a locked cabinet in the office to ensure the medication cart has enough space for the routine medication. The med cart and locked cabinets will be audited weekly **(Attachment H).**

### Legal Entity Representative



Signature

Michael Lupinsky, Administrator — Printed Name and Title

12/16/19 — Date

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## 185a - Implement Storage Procedures

### Regulations

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

Blood sugar readings in the residents' glucometers do not match readings documented on the residents' medication administration records.

Discrepancies for Resident #2 include:

- On 11/6/19, at 8 pm, a reading of 236 was recorded on the glucometer. A reading of 234 was on the MAR.
- On 11/5/19, at 12 pm, a reading of 181 was recorded on the glucometer. A reading of 180 was on the MAR.

### Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

**What:** The home shall ensure the residents' glucometers match the readings documented on the residents' medication administration records. (Quick Mar)
**Who:** The Resident Care Director or Designee will educate the Med Techs on Plan of Correction Training **(ATTACHMENT I)** and from our Best Practice Manual: The Med Tech Change of Shift Responsibilities **(ATTACHMENT J)** and Blood Sugar Confirmation Log **(ATTACHMENT K)** to ensure accuracy.
**When:** The Resident Care Director or Designee will complete audits of the Blood Sugar Confirmation log, Quick Mar, and the resident's glucometer.
**How:** Resident Care Director or Designee will accurately record glucometer readings in Quick Mar. Change of shift responsibilities including the Blood Sugar Confirmation Log completion will assure accurate information.
**Ongoing:** To ensure quality, the Resident Care Director or Designee will conduct monthly audits and report findings in the QA Meetings.

### Legal Entity Representative

[signature] Signature

Michael Lapinsky, Administrator — Printed Name and Title

12/16/19 — Date

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