Department of Human Services
Bureau of Human Service Licensing

July 20, 2022

[redacted], COO
[redacted]

RE: TRADITIONS OF HERSHEY
100 NORTH LARKSPUR ROAD
PALMYRA, PA, 17078
LICENSE/COC#: 33260

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/07/2022, 06/08/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *TRADITIONS OF HERSHEY* **License #:** *33260* **License Expiration:** *02/01/2023*

Address: *100 NORTH LARKSPUR ROAD, PALMYRA, PA 17078*

County: *LEBANON* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *GAHC3 PALMYRA PA ALF TRS SUB LLC*

Address: *660 SENTRY PARKWAY,SUITE 220, C/O HERITAGE SENIOR LIVING, BLUE BELL, PA, 19422*

Phone: [redacted] **Email:** *ccruz@traditionsofhershey.com*

Certificate(s) of Occupancy

Type: *I-1* **Date:** *06/29/2018* **Issued By:** *S Londonderry Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *39* **Waking Staff:** *29*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *06/08/2022*

Inspection Dates and Department Representative

06/07/2022 - On-Site: [redacted]

06/08/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served:** *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *30*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *9* **Have Physical Disability:** *1*

Inspections / Reviews

06/07/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/26/2022*

Inspections / Reviews *(continued)*

07/05/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/12/2022*

07/20/2022 - Document Submission

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Per the Care Facility Carbon Monoxide Alarms Standards Acts, the battery must be labeled with the date of installation and replaced at least once annually. The label on the battery operated carbon monoxide detector in the kitchen stated "replace by 2/21" as observed on 6/8/22 at 9:45am.

Plan of Correction ***Accept***

What: On 6/8/22 during the annual survey in the kitchen it was discovered that the battery in the carbon monoxide detector wasn't replaced within one year. It should have been replaced by 2/21/22.
The violation was corrected at the time of the survey on 6/8/22.
Who: The Executive Director will train the management team and the maintenance department on Plan of Correction - Carbon Monoxide Alarm Plan (Attachment A) and Battery Audit (Attachment B) and complete Sign in Sheet (Attachment C).
When : Training to be completed by 7/25/22
How : Maintenance Director will assure the carbon monoxide detector battery in the kitchen is replaced at least annually.
Ongoing : The maintenance director will conduct a monthly Quality Assurance audit of carbon monoxide detector batteries to ensure they are changed at least annually. Finding and trends will be reviewed at the QA meetings.
Completion Date: *06/08/2022*

Document Submission ***Implemented***

What: On 6/8/22 during the annual survey in the kitchen it was discovered that the battery in the carbon monoxide detector wasn't replaced within one year. It should have been replaced by 2/21/22.
The violation was corrected at the time of the survey on 6/8/22.
Who: The Executive Director will train the management team and the maintenance department on Plan of Correction - Carbon Monoxide Alarm Plan (Attachment A) and Battery Audit (Attachment B) and complete Sign in Sheet (Attachment C).
When : Training to be completed by 7/25/22
How : Maintenance Director will assure the carbon monoxide detector battery in the kitchen is replaced at least annually.
Ongoing : The maintenance director will conduct a monthly Quality Assurance audit of carbon monoxide detector batteries to ensure they are changed at least annually. Finding and trends will be reviewed at the QA meetings.
7/12/22- all steps have been implemented , final training completion date 7/25/22.

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

54a - Direct Care Staff *(continued)*

Plan of Correction ***Accept***

What: on 6/8/22 during the annual survey it was discovered that a direct care staff person didn't have a high school diploma , GED or active registry on the PA Nurse Adie Registry. The violation was corrected when the direct care staff person resigned without notice on 6/14/22.
Who: The Executive Director will train the management team, and the Business Office Department on ,Plan of correction- Direct Care Staff Education Qualification Plan(Attachment D) and QA Audit (Attachment E) and complete Sign in Sheet (Attachment F)
When : Training to to be completed by 7/25/22.
How: Business Office Director will assure direct care staff have a high school diploma , GED, or active registry on the PA Nurse Aide Registry upon hire.
Ongoing : The Business Office Director will conduct a quarterly Quality Assurance audit of direct care staff files to assure they have a high school diploma, GED or Active registry status on the PA nurse aide registry. Finding and trends will be reviewed at the QA meetings.
Completion Date: *06/14/2022*

Document Submission ***Implemented***

What: on 6/8/22 during the annual survey it was discovered that a direct care staff person didn't have a high school diploma , GED or active registry on the PA Nurse Adie Registry. The violation was corrected when the direct care staff person resigned without notice on 6/14/22.
Who: The Executive Director will train the management team, and the Business Office Department on ,Plan of correction- Direct Care Staff Education Qualification Plan(Attachment D) and QA Audit (Attachment E) and complete Sign in Sheet (Attachment F)
When : Training to to be completed by 7/25/22.
How: Business Office Director will assure direct care staff have a high school diploma , GED, or active registry on the PA Nurse Aide Registry upon hire.
Ongoing : The Business Office Director will conduct a quarterly Quality Assurance audit of direct care staff files to assure they have a high school diploma, GED or Active registry status on the PA nurse aide registry. Finding and trends will be reviewed at the QA meetings.
7/12/22- All steps have been implemented , final completion date 7/25/22.

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 6/8/2022 at approximately 10:15am, there was an uncovered, unattended trash can in the bathroom of resident room #[redacted]

Plan of Correction ***Accept***

What : On 6/8/22 during the annual survey in a [redacted] apartment there was an uncovered trash can in their bathroom. The violation was corrected at the time of the survey 6/8/22 when the trash can was removed.
Who: The Executive Director will train the management team and the Resident Care department on Plan of Correction - Trash Cares Covered Plan(Attachment G) and Audit(Attachment B) and complete (Sign in Sheet (attachment H).
When : Training to be completed by 7/25/22

85d - Trash Receptacles (continued)

How: Resident Care Director will conduct monthly Quality Assurance audit of shared bathrooms to assure trash cans are covered in bathrooms. Findings and trends will be reviewed at the QA meetings.

Completion Date: *06/08/2022*

Document Submission ***Implemented***

What : On 6/8/22 during the annual survey in a [redacted] *apartment there was an uncovered trash can in their bathroom. The violation was corrected at the time of the survey 6/8/22 when the trash can was removed.*
Who: The Executive Director will train the management team and the Resident Care department on Plan of Correction - Trash Cares Covered Plan(Attachment G) and Audit(Attachment B) and complete (Sign in Sheet (attachment H).
When : Training to be completed by 7/25/22
How: Resident Care Director will conduct monthly Quality Assurance audit of shared bathrooms to assure trash cans are covered in bathrooms. Findings and trends will be reviewed at the QA meetings.
7/12/22- All steps have been implemented, final completion 7/25/22.

183b - Meds and Syringes Locked

1. 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 6/8/2022 at approximately 1:30pm, a 2.5 oz container of Bio Freeze roll-on was found unlocked, unattended, and accessible beside the bed in the room of Resident #2.

Plan of Correction ***Accept***

What: On 6/8/22 during the annual survey in a residents' apartment a container of Bio Freeze was unlocked , unattended, and accessible beside the bed. The violation was corrected at the time of the survey on 6/8/22. It was removed and now stored by the Resident Care Department.
Who: The Executive Director will train the management team and resident care department on Plan Of Correction - Bio Freeze Storage Plan(Attachment l) and Audit (Attachment B)and complete Sign in Sheet (Attachment J)
When: Training to be completed by 7/25/22.
How: Resident Care Director will assure all medications and syringes are stored in a locked area or container.
Ongoing: The Resident Care Director will conduct monthly Quality Assurance audit of resident apartments to assure all medications and syringes are stored in a locked area or container. Findings and trends will be reviewed at the QA meetings.

Completion Date: *06/08/2022*

Document Submission ***Implemented***

What: On 6/8/22 during the annual survey in a residents' apartment a container of Bio Freeze was unlocked , unattended, and accessible beside the bed. The violation was corrected at the time of the survey on 6/8/22. It was removed and now stored by the Resident Care Department.
Who: The Executive Director will train the management team and resident care department on Plan Of Correction - Bio Freeze Storage Plan(Attachment l) and Audit (Attachment B)and complete Sign in Sheet (Attachment J)
When: Training to be completed by 7/25/22.
How: Resident Care Director will assure all medications and syringes are stored in a locked area or container.
Ongoing: The Resident Care Director will conduct monthly Quality Assurance audit of resident apartments to assure all medications and syringes are stored in a locked area or container. Findings and trends will be reviewed at the

183b - Meds and Syringes Locked (continued)

QA meetings.
7/12/22- All steps have been implemented, final completion 7/25/22.

184b - Resident's Meds Labeled

1. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 6/8/2022, a 4 fluid ounce package of [redacted] *and a 1 ounce* [redacted]*, which was half-used, both belonging to unknown resident(s) was found in the treatment cart. Neither of these medications were labeled with a resident's name.*

Plan of Correction ***Accept***

What : On 6/8/22 during the annual survey in the treatment cart skin prep was stored without indentification of the resident it belonged to . The violation was corrected at the time of the survey on 6/8/22 when it was removed.
Who: The Executive Director will train the management team and the Resident Care Department on Plan Of Correction- Skin Prep Label Plan- (Attachment K) and Audit (Attachment B) and complete Sign - in sheet(Attachment L).
When : Training to be completed by 7/25/22.
How: The Resident Care Director will assure all medications in the treatment cart are labeled with resident's name.
Ongoing : The Resident Care Director will conduct a monthly Quality Assurance audit of the treatment cart to assure all medications in the treatment cart are labeled with the resident's name. Findings and trends will be reviewed at the QA meetings.
Completion Date: *06/08/2022*

Document Submission ***Implemented***

What : On 6/8/22 during the annual survey in the treatment cart skin prep was stored without indentification of the resident it belonged to . The violation was corrected at the time of the survey on 6/8/22 when it was removed.
Who: The Executive Director will train the management team and the Resident Care Department on Plan Of Correction- [redacted] *- (Attachment K) and Audit (Attachment B) and complete Sign - in sheet(Attachment L).*
When : Training to be completed by 7/25/22.
How: The Resident Care Director will assure all medications in the treatment cart are labeled with resident's name.
Ongoing : The Resident Care Director will conduct a monthly Quality Assurance audit of the treatment cart to assure all medications in the treatment cart are labeled with the resident's name. Findings and trends will be reviewed at the QA meetings.
7/12/22- All steps have been implemented, final completion 7/25/22.

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #3 is prescribed 3 units of [redacted] *3 times per day with meals. However, the Medication Administration Record (MAR) shows that the morning dose was not given on June 1-4 and June 6-8, 2022.*

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept***

What: On 6/8/22 during the annual survey it was discovered that a resident was prescribed 3 units of [redacted], 3 times per day with meals. However, the Medication Administration Record (MAR) shows morning dose was not given on June 1-4 and June 6-8. The violation was corrected at the time of the survey on 6/8/22 when the physician was made aware and no changes to the prescribed medication was made.
Who: The Executive Director will train the management team and Resident Care Department on Plan of Correction - MAR Plan (Attachment M) and Audit (Attachment B) and complete Sign-In- Sheet (Attachment N).
When : Training to be completed by 7/25/22.
How: The Resident Care Director will assure all medications in the MAR are signed off prescribed medications. The Med Techs will review the QuickMar dashboard at the change of shift to make sure all medications have been given and documented.
Ongoing : The Resident Care Director will conduct a weekly Quality Assurance audit of QuickMar to assure prescribed medications have been signed off. Findings and trends will be reviewed at the QA meetings.
Completion Date: *06/08/2022*

Document Submission ***Implemented***

What: On 6/8/22 during the annual survey it was discovered that a resident was prescribed 3 units of [redacted], 3 times per day with meals. However, the Medication Administration Record (MAR) shows morning dose was not given on June 1-4 and June 6-8. The violation was corrected at the time of the survey on 6/8/22 when the physician was made aware and no changes to the prescribed medication was made.
Who: The Executive Director will train the management team and Resident Care Department on Plan of Correction - MAR Plan (Attachment M) and Audit (Attachment B) and complete Sign-In- Sheet (Attachment N).
When : Training to be completed by 7/25/22.
How: The Resident Care Director will assure all medications in the MAR are signed off prescribed medications. The Med Techs will review the QuickMar dashboard at the change of shift to make sure all medications have been given and documented.
Ongoing : The Resident Care Director will conduct a weekly Quality Assurance audit of QuickMar to assure prescribed medications have been signed off. Findings and trends will be reviewed at the QA meetings.
7/12/22- All steps have been implemented, final completion 7/25/22,

225a - Assessment 15 Days

1. 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

The initial assessment and support plan for Resident #1 who was admitted to the home on [redacted] was completed on [redacted]

Plan of Correction ***Accept***

What: On 6/8/22 during the annual survey it was discovered that a resident who moved in on [redacted] didn't have an initial assessment and support plan completed on time. It was done [redacted]. The violation was unable to be corrected at the time of the survey. The assessment and support plan cycle will follow the [redacted] completion date.
Who: The Executive Director will train the management team and the Resident Care Department on Plan of correction- Assessment 15 days Plan(Attachment O) and Audit(Attachment B) and complete Sign- In-Sheet (

225a - Assessment 15 Days (continued)

Attachment P).
When: Training to be completed by 7/25/22.
How: The Resident Care Director will assure all new residents have a completed assessment within 15 days and support plan within 30 days.
Ongoing: The Resident Care Director will conduct a weekly Quality Assurance audit for all new residents that have moved into the community to have a completed assessment within 15 days and support plan within 30 days. Finding as and trends will be reviewed at the QA meetings.

Completion Date: *07/25/2022*

Document Submission ***Implemented***

What: On 6/8/22 during the annual survey it was discovered that a resident who moved in on 10/1/20 didn't have an initial assessment and support plan completed on time. It was done 12/22/20. The violation was unable to be corrected at the time of the survey. The assessment and support plan cycle will follow the 12/22/20 completion date.
Who: The Executive Director will train the management team and the Resident Care Department on Plan of correction- Assessment 15 days Plan(Attachment O) and Audit(Attachment B) and complete Sign- In-Sheet (Attachment P).
When: Training to be completed by 7/25/22.
How: The Resident Care Director will assure all new residents have a completed assessment within 15 days and support plan within 30 days.
Ongoing: The Resident Care Director will conduct a weekly Quality Assurance audit for all new residents that have moved into the community to have a completed assessment within 15 days and support plan within 30 days. Finding as and trends will be reviewed at the QA meetings.
7/12/22- All steps have been implemented, final completion 7/25/22.