

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

April 27, 2023

[REDACTED], ADMINISTRATOR
HERSHEY OPERATIONS LLC
[REDACTED]
[REDACTED]

RE: HARMONY AT HERSHEY
75 EAST CANAL STREET
HERSHEY, PA, 17033
LICENSE/COC#: 33741

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/29/2023 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: HARMONY AT HERSHEY License #: 33741 License Expiration: 06/14/2023
 Address: 75 EAST CANAL STREET, HERSHEY, PA 17033
 County: DAUPHIN Region: CENTRAL

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: HERSHEY OPERATIONS LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 04/02/2021 Issued By: L&I
 Type: I-2 Date: 04/02/2021 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 99 Waking Staff: 74

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint Exit Conference Date: 03/29/2023

Inspection Dates and Department Representative

03/29/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 129 Residents Served: 68
 Secured Dementia Care Unit
 In Home: Yes Area: MC Capacity: 39 Residents Served: 26
 Hospice
 Current Residents: 5
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 68
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 31 Have Physical Disability: 1

Inspections / Reviews

03/29/2023 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/14/2023

04/14/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/25/2023
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/20/2023

Inspections / Reviews *(continued)*

04/19/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/25/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/26/2023

04/27/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/25/2023

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

On [REDACTED] Resident #1 eloped from the Secure Care Dementia Unit (SDCU) for approximately 2 to 2 and 1/2 hours. The home did not report this incident to the Department.

Repeat Violation - 9/29/22 and 2/16/23

Plan of Correction

Directed [REDACTED] - 04/17/2023)

Resident 1 incident report was completed by the Executive Director on [REDACTED], but staff member [REDACTED] did not fax to department. Executive Director will ensure that staff when directed will fax reportable to the department within 24 hours starting on 3/30/2023. Staff that is responsible for faxing required reportable to the state are all Directors, nursing and concierge staff. Executive Director educated all directors and concierge and nursing staff on 3/30/2023 the importance of sending reportable events. Executive Director will request the fax confirmation that it was completed. A spreadsheet will be created for reportable incidents with incident and fax to sign off to show completion.

[Directed]

Resident 1 incident report was completed by the Executive Director on [REDACTED] but staff member [REDACTED] did not fax to the Department. The Executive Director will ensure that staff when directed will fax reportable to the department within 24 hours starting on 3/30/2023. Executive Director educated all directors and concierge and nursing staff on 3/30/2023 the importance of sending reportable events, as well as the time frames required by the regulations. Starting on 3/30/2023, the Executive Director will request the fax confirmation after an incident report has been faxed into the Department. The Executive Director will create a spreadsheet for reportable incidents by 4/21/2023. The spreadsheet will include incident information and document fax confirmation was obtained. The Executive Director will document this information on the spreadsheet for each incident. Starting on 4/21/2023, incident reports and fax confirmations to the Department will be kept together in the home's Reportable Incident Binder. The Executive Director will be responsible for ensuring this binder stays up to date.

Directed Completion Date: 04/21/2023

Implemented [REDACTED] - 04/27/2023)

81b Resident Personal Equipment

2. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #2 has a bed rail on the left side of his/her bed. The bed rail is not securely attached to the bed. The bed rail was able to be pulled out approximately 4 to 6 inches when weight was applied, this presents a possible entrapment risk to the resident.

81b - Resident Personal Equipment (*continued*)**Plan of Correction**

Accept (█) - 04/17/2023)

Residents 2 siderail was immediately removed on 3/30/2023 by Maintenance Director and executive Director. Executive Director spoke with POA and sent them what is allowed and waiting to see if family will purchase. Executive Director educated the med techs and direct care staff on 3/30/2023 to report any side rails that are not secure to the Maintenance Director or Executive Director. Executive Director did an audit on 4/5/2023 of all residents and siderails to make sure they are compliant. The Maintenance Director or Executive Director will monitor all bed rails weekly to ensure compliance starting on 3/30/2023.

Licensee's Proposed Overall Completion Date: 04/17/2023

Implemented (█) 04/27/2023)

85a - Sanitary Conditions

3. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/29/23 at 8:25 AM, there was a large, covered trash can observed at the entrance of the dining room. There were soiled briefs, soiled clothing, and soiled bed pads located in the trash can.

Plan of Correction

Accept (█) - 04/17/2023)

On 3/29/2023 the large trash can was immediately removed by the Direct Care Staff from the dining area and placed in locked room behind the nursing desk. Directors, Med techs, Direct care staff, housekeeping was educated on 3/30/2023 on sanitary conditions and proper storing of the trash can. Executive Director or Harmony Square Director will monitor the trash can daily for 1 month to ensure compliance starting on 4/05/2023.

Licensee's Proposed Overall Completion Date: 04/17/2023

Implemented (█) - 04/27/2023)

187a - Medication Record

4. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 is prescribed █ However, resident #1's March 2023 medication administration record does not include the diagnosis for this medication.

Plan of Correction

Directed (█) - 04/17/2023)

Executive Director immediately on 3/29/2023 contacted the pharmacy to correct the diagnosis for this medication. The Executive Director or Healthcare Director will do weekly cart audits to ensure compliance starting on

187a - Medication Record (continued)

04/05/2023. Med techs and Nursing Directors was educated on 3/30/2023 to report when diagnosis is missing on the MAR to be corrected.

[Directed]

The Executive Director contacted the pharmacy on 3/29/23 and requested that a correct diagnosis for this medication be added to the Medication Administration Record (MAR) for Resident #1. The corrected MAR was received by the home on 3/29/23. The Executive Director or Healthcare Director will do weekly cart audits to ensure compliance starting on 04/05/2023. Medication Technicians and Nursing Directors was educated on 3/30/2023 by Executive Director to report when diagnosis is missing on the MAR to be corrected.

Directed Completion Date: 04/19/2023

Implemented (█) - 04/27/2023

187d - Follow Prescriber's Orders**5. Requirements**

2600.

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

Description of Violation

On █, resident #1's husband observed that the resident was lethargic and nauseous. The resident's husband observed that the resident had 3 █ patches on █ back. Resident #1's husband brought this to the attention of staff, who removed the patches from the resident's back. Per prescriber's instructions, a new patch is to be put on resident each day and the patch from the previous day is to be removed.

Repeat Violation - 9/29/22

Plan of Correction

Directed (█) - 04/18/2023

The Executive Director educated the Nursing Directors and med techs on 3/30/2023 that the home shall follow the directions of the prescriber. Executive Director or Healthcare will daily audits to ensure staff are following prescriber instructions for 1 month starting on 4/5/2023.

[Directed]

The Executive Director educated the Nursing Directors and Medication Technicians on 3/30/2023 regarding medications being administered as ordered by the prescriber. Starting 4/21/23, Executive Director and/or Healthcare Director will complete 4 random medication observations per month for 3 months to ensure staff are following prescriber instructions when administering medications.

Directed Completion Date: 04/21/2023

Implemented (█) - 04/27/2023

227e - Self Administer Medication**6. Requirements**

227e Self Administer Medication (continued)

2600.

227.e. The resident’s support plan must document the ability of the resident to self administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #1’s current Resident Assessment Support Plan (RASP) dated [redacted] states resident requires administration of medications and medication treatments. However, the resident’s current medical evaluation dated [redacted] states that the resident can self-administer with assistance in remembering schedule.

Plan of Correction

Directed ([redacted] - 04/17/2023)

Residents medical Evaluation was corrected on [redacted] by the Executive Director. Executive Director or Healthcare Director will audit all Medical Evaluations for accuracy on [redacted] [redacted] ensure that information reflect the same information. Executive Director educated the HealthCare Director on 3/30/2023 on Medical Evaluation forms. Starting on 3/30/2023 Healthcare Director will review medical evaluation forms when completing a resident's rasp.

[Directed]

Resident #1’s medical evaluation was corrected on [redacted] by the Executive Director. The Executive Director or Healthcare Director will audit all current medical evaluations and resident assessment support plans (RASP) on [redacted] to ensure they reflect the same information. The Executive Director educated the HealthCare Director on 3/30/2023 on medical evaluation and RASPs needing to have matching information. Starting on 3/30/2023 Healthcare Director will review medical evaluation forms when completing a resident's rasp.

Directed Completion Date: 04/19/2023

Implemented ([redacted] - 04/27/2023)

233c Key Locking Devices

7. Requirements

2600.

233.c. If key locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On [redacted] there were no directions for operation posted for the Secure Dementia Care Unit (SDCU) Exit door by room H102 leading outside or SDCU exit door leading to stairwell by room H101.

Plan of Correction

Accept ([redacted] - 04/17/2023)

They directions were posted immediately on 3/29/2023 by Healthcare director. Executive Director will do weekly checks to ensure directions to the SCDU is posted starting on 4/5/2023 for 1 month. Executive Director educated all departments to report immediately when any code is missing to all exits and entrances to the SDCU so they can be replaced to the Executive Director or HealthCare Director. The Executive Director or Healthcare Director should replace immediately upon being notified of any missing code.

Licensee's Proposed Overall Completion Date: 04/17/2023

Implemented ([redacted] - 04/27/2023)

234b Support Plan Needs Elements

8. Requirements

234b - Support Plan Needs Elements (continued)

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated [REDACTED], for resident #1 does not address the resident's elopement incident on [REDACTED] or interventions for prevention of future elopement incidents.

Plan of Correction**Directed ([REDACTED] - 04/17/2023)**

Resident support plan was immediately updated on [REDACTED] by the Executive Director for future elopement incidents. The Executive Director Educated the Directors, Med techs, PCA's on the policy and procedure of an elopement on [REDACTED]. An audit on 4/5/2023 of all support plans to ensure that we are meeting the needs of the residents by the Executive Director. Executive Director or Healthcare Director will be responsible for updating all rasps. Executive Director or Healthcare Director when there is a change in status or incident that it will be completed immediately or reported immediately to ensure compliance.

[Directed]

Resident #1's support plan was immediately updated on [REDACTED] by the Executive Director for future elopement incidents. The Executive Director educated the Directors, Medication Technicians, and Personal Care Assistants on the policy and procedure of an elopement on [REDACTED]. An audit on 4/5/2023 of all support plans to ensure that we are meeting the needs of the residents by the Executive Director. Executive Director or Healthcare Director will be responsible for updating all resident assessment support plans (RASP). Starting on 4/5/2023, Executive Director or Healthcare Director will update RASPs when there is a change in status or incident with a resident. The RASP will be updated within 48 hours when a change in status occurs or there is an incident with a resident.

Directed Completion Date: 04/19/2023**Implemented ([REDACTED] - 04/27/2023)**

254a - Records Discharge/Active

9. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 3/29/23 at 4:38 PM, laptop computer was observed on the Secure Dementia Care Unit SDCU medication cart and was unsupervised and unsecure. 18 SDCU residents' medication information was accessible on the laptop screen.

On 3/29/23 at 4:56 PM, a laptop computer was observed on the Personal Care (PC) 2nd floor medication cart and was unsupervised and unsecure. 18 PC residents' medication information was accessible on the laptop screen.

Repeat Violation - 9/29/22

254a Records Discharge/Active (continued)

Plan of Correction

Accept (█ - 04/17/2023)

Executive Director educated staff in all departments on 3/30/2023 on records discharge or active. Executive Director or Healthcare Director will ensure compliance by doing daily rounds and monitoring all floors for laptops containing privacy information starting on 3/30/2023 for 1 month to ensure compliance.

Licensee's Proposed Overall Completion Date: 04/14/2023

Implemented (█ - 04/27/2023)