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

July 24, 2023

[redacted], COO
GAHC3 PALMYRA PA ALF TRS SUB LLC
[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 06/22/2023 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: *TRADITIONS OF HERSHEY* **License #**: *33260* **License Expiration**: *02/01/2024*

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: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/29/2018* **Issued By**: *South Londonderry Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/22/2023*

Inspection Dates and Department Representative

06/22/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *31*

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

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

06/22/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/08/2023*

07/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/21/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/14/2023*

Inspections / Reviews *(continued)*

07/14/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/24/2023*

07/24/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2023*

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

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Member A, whose first day of work was [redacted], did not receive orientation on the following topics until 2/19/2023: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, telephone use and notification of emergency services, smoke detectors and fire alarms.

Plan of Correction ***Accept ([redacted] - 07/14/2023)***

65A-

What: On 6/22/23 during annual survey of employee records it was discovered that staff member A (A rehired staff member) whose first work day was [redacted] did not receive orientation on the following topics until 2/19/23. Evacuation procedures, staff duties and responsibilities during fire drills, emergency evacuation, transportation, designated meeting place outside building or within fire safe area in the event of an actual fire, smoking safety procedures, the homes smoking policy and locations of smoking areas (if applicable) location and use of fire extinguishers, telephone use, notification of emergency services, smoke detectors, and fire alarms.

Who: Executive Director educated managers on violation and plan of correction on 6/23/23 & 6/26/23.

When: Training completed on 6/23/23 & 6/26/23. (See attachment A- Training content, and signature page.)

How: Business Office Manager will assure that all new and rehired employees complete Fire Safety and emergency preparedness training during the employees first work day. (See attachment B- Orientation training plan checklist)

Ongoing: Business Office Manager will conduct Quality Assurance audits of new and rehired employees to ensure compliance, findings and trends will be reviewed at the Quality Assurance meetings.

See attached documents A and B.

Correction update: The Training Plan Checklist wasn't newly developed. It was revised 6/22/23 and implemented 6/27/23. Business Office Manager completed employee education audit on 7/11/23, see attachment B-2. Business Office Manager will complete audits quarterly , see attachment A #7.There have been no new hires or rehires since the date of inspection 6/22/2023.

Licensee's Proposed Overall Completion Date: *07/14/2023*

65a - FS Orientation 1st Day *(continued)*

Implemented (- 07/24/2023)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Member A, whose first day was , did not receive training on the Emergency Medical Plan until 3/2/2023. Additionally, Staff Member A did not complete training in the following topics: resident rights, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Directed (- 07/14/2023)***

65B-
What: On 6/22/23 during annual survey of employee records it was discovered that staff member A (A rehired staff member) whose first work day was did not receive orientation on the following topics until 3/2/23. Resident Rights, Mandatory reporting of abuse and neglect under the Older Protective Services Act (35 P.S. 10225.101-10225.5102).
Who: Executive Director educated managers on violation and plan of correction on 6/23/23 & 6/26/23.
When: Training completed on 6/23/23 & 6/26/23. (See attachment A- Training content, and signature page.)
How: Business Office Manager will assure that all new and rehired employees complete Resident Rights, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act training within 40 scheduled working hours of the employees first work day. (See attachment B- Orientation training plan checklist)
Ongoing: Business Office Manager will conduct quarterly Quality Assurance audits of new and rehired employees to ensure compliance, findings and trends will be reviewed at the quarterly Quality Assurance meetings.

See attached Plan of correction for 65 B.
See attachments A and B for 65A & 65B.
Correction update: The Training Plan Checklist wasn't newly developed. It was revised 6/22/23 and implemented 6/27/23. Please reference Attachment A #7 noting Business Office Manager will conduct audits quarterly. There have been no new hires or rehires since the date of inspection 6/22/2023. Employee education audit was completed by Business Office Manager on 7/11/2023, see attachment B2. Employee A completed Abuse training on 7/2/2023, see attachment B3page 3of 5.

(Directed)
Staff Member A received education on Resident Rights on 7/3/2023 and OAPSA Abuse on 7/2/2023 and

65b - Rights/Abuse 40 Hours *(continued)*

Directed Completion Date: *07/14/2023*

Implemented (- 07/24/2023)

85a - Sanitary Conditions

3. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at [redacted] and [redacted], Resident #1's glucometer was used to check Resident #2's blood glucose levels.

Plan of Correction ***Accept (- 07/14/2023)***

85A-
What: On 6/22/23 during annual survey and inspectors review of submitted state reportable incidents since last inspection, inspector reviewed on 3/16/23 at 8:10Pm and 9:40PM, resident # 1's glucometer was used to check resident # 2's blood sugar. Even though Traditions of Hershey reported the incident when it occurred on 3/16/23, inspector stated it is an automatic violation of 85A.
Who: Executive Director educated managers on violation on 6/23/23.
When: Incident was reported to the Department of Human Services within 24 hours of the incident on 3/16/23. (See attachment C – reportable incident)
How: Prior to the incident Resident # 1 and Resident # 2, each had their own glucometer and supplies, in separate containers, with their name and room number on the outside of the supply container. On 3/17/23 Resident Care Director and Executive Director add photograph of resident to the outside of the resident supply containers. (See attachment D for Resident # 2, please note that resident # 1 is no longer a resident, and passed away under Hospice Care on 5/24/23.)
Incident was corrected addressed, reported at the time of occurrence on 3/17/23, there have been no further incidents since 3/16/23.
Ongoing : Resident Care Director conducts quarterly medication cart audits during quarterly Quality Assurance audits, trends will be reviewed at the Quality Assurance meetings.

See attached Plan of correction for 85A.
See attachments C and D.
Correction update:
On 3/17/2023 when it was discovered by [redacted] (Medtech) notified resident Resident # 1 and Resident # 2 physicians and POA / Responsible party.

Med tech responsible for glucometer error on 3/16/23, Brandon Laboy received re-education by [redacted] (Resident Care Director) on 3/18/2023, 5 Rights of Medication Administration. To date there have been no further incidents.

Resident Care Director will complete monthly glucometers observations for medication techs starting 7/11/2023.

Licensee's Proposed Overall Completion Date: *07/14/2023*

85a - Sanitary Conditions *(continued)*

Implemented [redacted] - 07/24/2023)

88a - Surfaces

4. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 6/22/2023, the mechanical ventilation systems in the bathrooms of resident room #203 and resident room #205 were observed to be covered in a thick layer of dust with potential to prevent proper ventilation.

Plan of Correction ***Accept [redacted] - 07/14/2023)***

88A-
What: On 6/22/23 during annual survey and inspectors review of resident rooms it was discovered that Resident rooms # 203 and 205 ceiling bathroom vent covered in thick layer of dust.
Who: Executive Director educated managers on violation on 6/23/23. Executive Director met with Maintenance Director on 6/26/23 to review violation and plan of correction.
When: Training completed on 6/26/23. (See attachment E- training and signature page.)
How: Maintenance Director will audit resident rooms weekly 7/3/23- 9/29/23, all resident rooms, weekly thereafter checking minimum of 5 resident rooms. (see attachment F – audit tool)
Ongoing: Maintenance Director will conduct Quality Assurance audits of resident rooms, findings and trends will be reviewed at the Quality Assurance meetings.

See attached Plan of correction for 88A.
See attachments E and F.
Correction update:
Rooms #203 and #205 were cleaned on 6/23/23 by maintenance assistant Chris Moyer.
See Attachment E for education corrections: [redacted] *(Maintenance Director) provided education on 6/26/23 for the follow Housekeepers:* [redacted].

Licensee's Proposed Overall Completion Date: *07/14/2023*

Implemented [redacted] - 07/24/2023)

190a - Completion Medication Course

5. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member A

190a - Completion Medication Course (continued)

, has not successfully completed the Department-approved medications administration course as Staff Member A did not complete the required Medication Administration Observations following the passing of the exam. Additionally, a certified trainer did not sign or date the training online examination portion of the summary and certification initial training form. Staff Member A administered medications to residents in June of 2023.

Staff Member C has not fully completed an annual practicum since 9/11/2020. Staff Member C administered medications in June of 2023.

Plan of Correction ***Accept (- 07/14/2023)***

190A-
What: On 6/22/23 during annual survey and review of medication tech training records it was discovered that Staff Member A has not successfully completed the Department – approved medications administration course as staff member A did not complete the required Medication Administration Observations following passing the exam. Additionally, a certified trainer did not sign or date the training online examination portion of the summary and certification initial training form.
Staff member C has not fully completed an annual practicum since 9/11/2020.
Who: Executive Director met with and educated Resident Care Director on the violation and plan of correction on 6/23/23.
When: 6/23/23
How: Staff member A was immediately removed from the schedule as a Med tech on 6/23/23, only being scheduled as a Resident Assistant. (See attachment G schedule for Staff Member A)
Staff member C- Annual practicum completed on 6/27/23 – (See attachment H- training forms and attachment I – Certified trainer certificate.)
Ongoing: Resident Care Director will conduct quarterly Quality Assurance audits of training records to ensure compliance, findings and trends will be reviewed at the Quality Assurance meetings.

See attached Plan of correction for 190A.
See attachments G , H and I.

Licensee's Proposed Overall Completion Date: *07/14/2023*

Implemented (- 07/24/2023)