pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HERSHEY OPERATIONS LLC**
LEGAL ENTITY

To operate **HARMONY AT HERSHEY**
NAME OF FACILITY OR AGENCY

Located at **75 EAST CANAL STREET, HERSHEY, PA 17033**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **129**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 39**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 20,** **2024** until **March 20,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **337412**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: SEPTEMBER 20, 2024

[redacted], Administrator
Hershey Operations LLC
[redacted]

RE: Harmony at Hershey
75 East Canal Street
Hershey, Pennsylvania 17033
License #: 337412

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on April 23-24, 2024, April 26, 2024 and June 24-25, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) and 55 Pa. Code §20.71(a)(1);(4);(5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed.

If you disagree with the decision to issue a SECOND PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *HARMONY AT HERSHEY* **License #:** *33741* **License Expiration:** *06/21/2024*

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:** *Labor and Industry*

Type: *I-2* **Date:** *04/02/2021* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *104* **Waking Staff:** *78*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident, Interim* **Exit Conference Date:** *04/26/2024*

Inspection Dates and Department Representative

04/23/2024 - On-Site: [redacted]

04/24/2024 - On-Site: [redacted]

04/26/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *129* **Residents Served:** *66*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square* **Capacity:** *39* **Residents Served:** *22*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *65*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *38* **Have Physical Disability:** *2*

Inspections / Reviews

04/23/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/23/2024*

05/29/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/05/2024*

06/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/24/2024*

09/05/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

42b - Abuse

1. Requirements

2600.
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 12/25/2023, staff witnessed Resident 1 punching Resident 2 in the back and sides repeatedly. Once staff was able to stop Resident 1, Resident 2 then slapped Resident 1.

On 01/16/2024, Resident 3 reported to staff that Resident 4 put [redacted] hands around the neck of Resident 3. Staff asked Resident 4 if [redacted] did this, and Resident 4 confirmed [redacted] did put their hands around Resident 3's neck.

On 01/24/2024, Resident 5 reported to staff that Staff Person A is rough, pulls Resident 5's arms when providing care and is also degrading to the resident about their incontinent issues. Upon interviewing Resident 5, Resident 5 disclosed feeling uncomfortable being handled by former Staff Member A. Resident 5 stated Staff Person A grabbed the resident underneath [redacted] arm and hurt them. The resident stated [redacted] knee was also twisted by Staff Person A when the resident was being handled by Staff Person A, which was painful. The resident stated [redacted] was "scared of the staff member".

On 02/01/2024, Resident 2 was found on the floor screaming "Get [redacted] away from me". Resident 1 was standing over Resident 2. When staff attempted to redirect Resident 1, Resident 1 began swinging [redacted] fists and struck Resident 6, who was in close proximity. After the incident, Resident 2 reported that Resident 1 hit [redacted] and knocked [redacted] over. Resident 2 complained of sore left forearm and had a small bruise as a result of the incident.

On 02/23/2024, Resident 2 was heard by staff yelling from the activities room. Staff then witnessed Resident 1 punching Resident 2 in the face and stomach.

On 03/11/2024, staff heard yelling. Upon investigating staff witnessed Resident 7 slapping Resident 8 in the face.

On 03/20/2024, staff was made aware of an incident which occurred in the theater of the home. An independent living resident reported to staff that Resident 9 was watching a movie when Resident 10 arrived at the theater. Resident 10 asked Resident 9 to move out of a specific seat Resident 10 wanted. Resident 9 refused to move seats and stated it was not Resident 10's seat. Resident 10 began yelling at Resident 9, and Resident 9 stood up from the seat, grabbed the shoulders of Resident 10. Both residents lost their balance and fell. Resident 9 sustained a swollen area on the back of the head, and Resident 10 complained of soreness in the bilateral shoulder area as a result of the incident. Upon interviewing Resident 9, Resident 9 reported that there was an altercation in the theater but could not recall the other resident's name that [redacted] got into an altercation with. Resident 9 reported the other resident who confronted [redacted] about a seat was abrasive and "challenged" [redacted] Resident 9 reported [redacted] "accepted the challenge" and hit the other resident. Resident 9 stated "I knocked them out".

On the morning of 04/24/2024, Resident 5 reported to 1st shift staff that [redacted] was upset about not being checked on throughout the early morning of 04/24/2024 and was sitting in [redacted] urine for an extended period of time. Resident 5 reported [redacted] was last checked on around 2:00AM. After 2:00AM, resident reported [redacted] rang [redacted] call bells, but no one came.
The call bell logs showed the following:
On 04/24/2024 at 06:13AM, the bedside call bell was pressed and was not answered for over 66 Minutes.

42b - Abuse (continued)

On 04/24/2024 at 06:29AM, the resident's pendant was pressed and was not answered for over 40 Minutes. It was discovered that Staff Person B was the one who was assigned to Resident 5 that night/morning.

Repeated Violation - 08/08/2023, et al

Plan of Correction ***Directed (- 06/06/2024)***

Incident 12.25.2023
-Residents 1 and 2 were separated immediately. Resident 2 was evaluated by HMC provider and 12/26/2023. Residents 1 and 2 Power of Attorney and Providers were notified on 12/25/2024 by Harmony Square Director The incident reportable was sent to the Department of Human Services and Area Agency on Aging on 12/26/2024.
-As a proactive measure Care staff did rounds on resident 1 every 30 minutes for 2 weeks this started on 12/25/2024.
-The Administrator and designee will continue to proactively seek Skilled placement for resident 1 this started 12/26/2024. The Memory Care Nurse or designee started to oversee the monitoring of Resident 1 when in any activities with Resident 2 on 05/06/2024. The Memory Care Nurse or designee is to document any noted behaviors daily during scheduled activities for 2 months and keep them for department review this will start 05/06/2024. the Harmony Square Director will update any behaviors noted in Activities and document on RASP starting 05/06/2024 and keep them for department review.
-Incident 02.01.2024
-Residents 1,2 and 6 were separated and evaluated for further treatment at the time of the incident. Residents 1,2 and 6 Power of Attorney and providers were notified of the incident on 02/01/2024 by Harmony Square Director. The incident reportable sent to the Department of Human Services and Area Agency on Aging on 02/01/2024 by Harmony Square Director
-As a proactive measure Care staff started rounds on 02/01/2024 on resident 1 every 30 minutes for 2 weeks.
-The Administrator and designee will continue to proactively seek Skilled placement for Resident 1 this started on 12/26/2023. The Memory Care Nurse or designee will start overseeing the monitoring of Resident 1 when in any scheduled activities with Residents 2 and 6 starting 05/06/2024. The Memory Care Nurse or designee is to document any noted behaviors daily during scheduled activities for 2 months and keep them for department review starting 05/06/2024. Memory Care Director will update RASPs with any observed behaviors and keep on file for Department Review.
-Incident 02/23/2024
-Residents 1 and 2 were separated upon the incident. Resident 2 was evaluated by LPN on 02/23/2024 and then evaluated by HMC providers and on 02/26/2024.
Residents 1 and 2 Power of Attorney and providers were notified of the incident on 02/23/2024. The incident reportable was sent to the Department of Human Services and Area Agency on Aging on 02/23/2024 all reports were completed by
-As a proactive measure Care staff did rounds on Resident 1 every 30 minutes for 2 weeks starting 02/23/2024.
-The Administrator and designee will continue to proactively seek Skilled placement for Resident 1 this started 12/26/2023. The Memory Care Nurse or designee will oversee the monitoring of Resident 1 when in any scheduled activities with Residents 2 and 6 starting 05/06/2024. The Memory Care Nurse or designee is to document any noted behaviors daily during scheduled activities for 2 months and keep them for department review starting 05/06/2024.
-Incident 01/16/2024
-Resident 3 was assessed for further evaluation after the incident by LPN . Power of Attorney and Providers were notified of this incident on 01/16/2024.
- Resident 4 was Discharged to
-Resident 3 was Discharged to

42b - Abuse (continued)

Incident 01/24/2024
-Resident 5 communicated concerns to the floor nurse on 01/24/2024 and [redacted] immediately notified the Administrator the same day. Upon notification, the employee was immediately suspended pending investigation on 01/24/2024. Power of Attorney and Providers were notified of this incident on 01/24/2024. Reportable Incident was sent to the Department of Human Services and Area Agency on Aging on 01/24/2024.
-Investigation was completed by the Area Agency on Aging, and employee [redacted] was terminated. The Area Agency on Aging did have a backlog of investigations and [redacted] was termed on [redacted]
Incident 04/24/2024
-Resident 5 communicated concerns to the Lead Day shift Medication Technician on 04/24/2024. The Lead Technician notified the Administrator after the conversation and the Administrator immediately suspended [redacted] on [redacted] pending investigation. Power of Attorney and Providers were notified of this incident on 04/24/2024 by [redacted] The incident reportable was sent to the Department of Human Services and Area Agency on Aging on 04/24/2024 by [redacted]
-Investigation was completed by the Department of Human Services on 04/25/2024, and employee [redacted] was terminated on [redacted]
Biweekly call bell audits will be completed starting the week of 06/03/2024. This will be documented and kept on file for Department Review.
Inservice completed on 06/7/2024 by [redacted] on response times for call bells.
Incident 03/11/2024
-Residents 7 and 8 were separated upon the incident. Resident 8 was evaluated with no injury by [redacted] on 03/11/2024. Power of Attorney and Providers were notified of this incident on 03/11/2024. The incident Was sent to the Department of Human Services and Area Agency on Aging by [redacted] on 03/12/2024.
03/20/2024

03/20/2024
-Residents 9 and 10 were separated and the Medication Technician assessed and sent Resident 10 for evaluation to [redacted] on 3/20/2024. The Power of Attorney and providers were notified on 03/20/2024 by [redacted] Health Care Director.
-The administrator has hung signs in the Theatre that seats are on a first come first serve basis on 05/06/2024. If anyone has seating issues see the on-duty concierge.
- Administrators or designees will complete abuse training every month at all staff meetings starting May 23, 2024, and then once monthly following for the year 2024.

Proposed Overall Completion Date: 06/26/2024

[Directed]

Incident 02/01/2024

- *Starting 05/06/2024, Memory Care Director [redacted] will update RASPs with any observed behaviors and will be kept and available for review by the Department.*

Incident 02/23/2024

- *Starting 05/06/2024, Memory Care Director [redacted] will update RASPs with any observed behaviors and will be kept and available for review by the Department.*

Incident 01/16/2024

42b - Abuse (continued)

- *The Memory Care Nurse or designee is to document any noted behaviors daily for 2 months and keep them for department review starting 05/06/2024.*
- *Starting 05/06/2024, Memory Care Director [redacted] will update RASPs with any observed behaviors and will be kept and available for review by the Department.*

Incident 01/24/2024

- *Starting 06/17/2024, the administrator and/or designee will complete a sample of resident interviews monthly to ensure residents feel safe in the home. Documentation of these interviews will be kept and available for review by the Department.*

Incident 04/24/2024

- *Starting 06/03/2024, the administrator and/or designee will complete bi-weekly call bell audits. This will be documented and kept on file for Department Review.*

Incident 03/11/2024

- *The Memory Care Nurse or designee is to document any noted behaviors daily for 2 months and keep them for department review starting 05/06/2024.*
- *Starting 05/06/2024, Memory Care Director [redacted] will update RASPs with any observed behaviors and will be kept and available for review by the Department.*

03/20/2024

- *Starting 06/17/2024, the administrator and/or designee will complete a sample of resident interviews monthly to ensure residents feel safe in the home. Documentation of these interviews will be kept and available for review by the Department.*
- *Starting 06/17/2024, the administrator and/or designee will update RASPs with any observed behaviors and will be kept and available for review by the Department.*

Directed Completion Date: *06/26/2024*

Not Implemented ([redacted] - 09/05/2024)

65i - Training Record

2. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The administrator conducted staff training on regulatory requirements after a licensing inspection on 01/09/2024. The training documentation does not include the date of the training or the length/duration.

Plan of Correction ***Accept ([redacted] - 06/06/2024)***

Training dates and times are updated and documented on training forms for the last Plan of Corrections on 04/26/2024 by [redacted].
-[redacted] Operations Specialist educated the Harmony Manager Team on Inservice dates and times on 04/ 29/2024.
-The administrator will have the Business Office Manager second check and initial dates and times of training for all Plan of Correction In-Services. This will remain on file for department review. This will begin 05/06/2024 and will

65i - Training Record (continued)

continue for 2 months. They will be reviewed within 48 hours and initialed by BOM.

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented ([redacted] - 09/05/2024)

85d - Trash Receptacles

3. 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 04/23/2024 at 3:46PM, there was a trash can observed near the dishwashing area of the kitchen which had a built-in hole in the lid, which in turn does not provide full coverage for the trash. At the time of observation, there were no staff near the trash can.

Plan of Correction ***Accept ([redacted] - 06/06/2024)***

The Dining Director completed in-service on 5/15/2024 with staff regarding regulation 85d.
New Trash Receptacle lids were purchased at Lowes on 04/26/2024 by [redacted] Dining Director and directly implemented with the kitchen staff after the surveyor reported concern. The new receptacle lids and pictures have been uploaded.
The Dining Director will complete bi-weekly audits and start 05/15/2024 to ensure we comply with regulation 85d document audit and findings and keep them on file for department review. This will continue for four weeks.

Licensee's Proposed Overall Completion Date: *06/12/2024*

Implemented ([redacted] - 09/05/2024)

103g - Storing Food

4. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 04/23/2024 at 3:44PM, there were 6 containers of uncovered ice cream in the ice cream freezer.

Plan of Correction ***Accept ([redacted] - 06/06/2024)***

The staff was using plastic wrap to cover the Ice Cream after meals. The Dining Director ordered hard removable covers on 04/26/2024 for the Ice Cream in the freezer. The covers arrived the day after the inspection. They were put into place immediately by the Dining Director.
The Dining Director In serviced staff on 05/15/2024 regarding regulation 103g. The Dining Director educated them on the process of covering the ice cream.
The Dining Director will audit the Ice cream station biweekly to ensure we maintain compliance with regulation 103g this will start 05/15/2024. The Dining Director will document the audit for four weeks and keep the audit on file for department review.

Licensee's Proposed Overall Completion Date: *06/12/2024*

103g - Storing Food *(continued)*

Implemented (- 09/05/2024)

183e - Storing Medications

5. Requirements

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 04/24/2024 at approximately 3:20PM, a light blue round pill was observed to be loose on the bottom of the drawer in the medication cart in the home's secure dementia care unit (SDCU).

On 04/24/2024, blister #30 on a blister pack containing Acetaminophen 325mg tablets for Resident 13 had been previously punctured, and the two tablets were placed back into the blister and taped. Staff had initialed and written "error" next to the popped blister.

Plan of Correction ***Accept (- 06/06/2024)***

The blue loose pill was removed and destroyed by [redacted] Medication Technician from the cart. The Tylenol was removed and the tape was also removed from the card and cart by [redacted]
16oz Drug Busters have been added to each cart to also help maintain compliance with loose pills by [redacted] on 06/03/2024.
Administrator or designee completed Inservice on 05/15/2024 with Clinical staff regarding regulation 183e. HCD/HSD or designee to complete medication cart audits. This will be completed bi-weekly to ensure compliance with regulations on 05/06/2024. The audit will be documented for 4 weeks. The audit will be kept on file for department review.

Licensee's Proposed Overall Completion Date: *06/12/2024*

Implemented (- 09/05/2024)

187d - Follow Prescriber's Orders

6. Requirements

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

Description of Violation

Resident 11 is prescribed Midodrine HCL 5mg tablet with directions to take one tablet by mouth 3 times a day for hypotension; hold for SBP >130.
On 03/09/2024 at 12:00PM, the resident had a documented SBP reading of 125, and Midodrine was not administered.
On 03/10/2024 at 8:00AM, the resident had a documented SBP reading of 127, and Midodrine was not administered.

Resident 11 had physician's orders to receive Acetaminophen 500mg with directions to take two tablets PO once daily PRN, effective 11/10/2023. However, on 11/11/2023, the resident was administered this medication at 12:12AM and again at 4:41AM.

187d - Follow Prescriber's Orders (continued)

Repeated Violation - 11/07/2023, et al and 08/08/2023, et al

Plan of Correction ***Accept (- 06/06/2024)***

HCD/HSD completed a medication error report after the survey on 05/14/2024 with the plan of correction regarding the findings in violation 187.d. HCD/HSD notified all appropriate parties.
Administrator and designee in-serviced Clinical Staff on parameter and PRN medications on 05/15/2024.
HCD and HSD to complete twenty-five MAR audits including and focusing on PRN and Parameter medications starting 05/06/2024. HCD/HSD to document audits and these audits will be kept for dept review. This will continue for 5 weeks.

Licensee's Proposed Overall Completion Date: *06/14/2024*

Implemented (- 09/05/2024)

224a - Preadmission Screen Form

7. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 5 was initially admitted to Personal Care Home on [redacted] under respite care. Resident was then discharged from personal care and moved into independent living. On [redacted], resident was re-admitted to personal care. However, the only preadmission screening form that was completed for the resident was on [redacted]

Repeated Violation - 11/07/2023, et al and 08/08/2023, et al

Plan of Correction ***Accept (- 06/06/2024)***

HCD completed the Prescreen for Resident 5 the day after the inspection 04/26/2024. Noted on document completed upon audit on 05/14/2024.
Administrator completed Inservice with HCD/HSD staff regarding regulation 224a 05/15/2024.
The Chief Nursing Officer completed the Prescreen audit on 05/14/2024. Audit kept on file for Department review.
Administrator to review all new residents and residents that transfer within the community to ensure compliance with regulation 224a starting 05/15/2024. This audit will continue for four weeks and be kept on file for department review.

Licensee's Proposed Overall Completion Date: *06/12/2024*

Implemented (- 09/05/2024)

[redacted]

[redacted]

WITHDRAWN - [redacted] - 9.16.24

[redacted]

227g -Support Plan Signatures

10. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The assessor participated in the development of Resident 10's RASP, dated [redacted] However, the assessor did not sign or date the support plan.

[redacted] *WITHDRAWN - [redacted] -9/16/24*

The Assessor participated in the development of Resident 11's RASP dated [redacted]. However, the Assessor did not

227g -Support Plan Signatures (continued)

sign or date the support plan.
Resident 11's family member participated in the development of Resident 11's RASP dated [redacted]. However, the family member did not sign or date the support plan.
[redacted] *WITHDRAWN -* [redacted] *9/16/24*

[redacted] *WITHDRAWN -* [redacted] *-9/16/24*
[redacted] *WITHDRAWN* [redacted] *9/17/24*
The Assessor participated in the development of Resident 12's RASP dated [redacted]*. However, the Assessor did not sign or date the support plan.*
Resident 12's support plan dated [redacted] *does not have the Resident's signature or date.* [redacted] *WITHDRAWN* [redacted] *9/17/24*

Plan of Correction ***Accept (*** [redacted] ***- 06/06/2024)***

Administrator in-serviced HCD/HSD on regulation 227g on 05/15/2024.
HCD/HSD to audit support plans for residents 10,11,12 review with POA and or resident for understanding and signature and document upon audit findings reviewed with resident and or POA. This was started on 05/16/2024. This will be kept for department review.
HCD/HSD to review and audit all care plans to check for signature completion. If no signature HCD/HSD to review with the POA and resident for understanding and signatures and document upon audit findings reviewed with the resident and POA. This will be kept for department review. These audits will start 05/16/2024.
Administrator to review all care plans and initial date of audit on all new support plans for 4 weeks to ensure compliance with regulation 227g. The support plans will be kept for department review. The start date to begin the audit is 06/03/2024 and completed by 06/19/2024.

Licensee's Proposed Overall Completion Date: *06/19/2024*

Implemented ([redacted] ***- 09/05/2024)***

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

Facility Information

Name: *HARMONY AT HERSHEY* **License #:** *33741* **License Expiration:** *06/21/2024*

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:** *Labor and Industry*

Type: *I-2* **Date:** *04/02/2021* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *86* **Waking Staff:** *65*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date:** *06/25/2024*

Inspection Dates and Department Representative

06/24/2024 - On-Site: [redacted]

06/25/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *129* **Residents Served:** *64*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square* **Capacity:** *39* **Residents Served:** *20*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *63*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *22* **Have Physical Disability:** *2*

Inspections / Reviews

06/24/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/25/2024*

07/31/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/30/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2024*

08/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/30/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/30/2024*

09/05/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/30/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 06/24/2024, at 10:15AM, the Department requested access to the facility's internal investigation documents for various incidents that occurred on 05/14/2024 and 05/17/2024. Staff Person A stated that some of the documents were located off-site at Staff Person A's personal residence. Staff Person A was not available and that the records would not be available until [redacted] returns on 07/02/2024.

On 06/24/2024, at 10:50AM, 7 resident records were requested. Medical records for Resident 1 and Resident 2 were not received until 12:20PM, and Staff Person E stated that they were being "audited" before they were provided to the Department. Resident admission information and contracts were not received until 1:02PM.

Plan of Correction ***Accept ([redacted] - 08/07/2024)***

Administrator conducted the interviews at the time of the incident and were in the administrator's notebook while [redacted] was on vacation at the time of inspection.
-The interviews will be added to a Word document and be kept on file for review by the department by August 7, 2024.
-The administrator will inform the in-service managers of regulation 5a1 by Aug 7, 2024.
-Upon survey, the Administrator and Director of Nursing will collect files within 45 minutes of requesting the specific patient information. This will begin on August 24.
-The Administrator will keep investigation documentation in the State Binder of Incident Reports. The Administrator will maintain the binder in [redacted] office for immediate need to file all investigation reports and to deliver to the Surveyor as requested.

Proposed Overall Completion Date: 08/24/2024

Licensee's Proposed Overall Completion Date: *08/24/2024*

Not Implemented ([redacted] - 09/05/2024)

15a - Resident Abuse Report

2. Requirements

2600.
15.a. The home 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 05/14/2024 between the hours of 3:00PM-7:00PM, former Staff Person B observed suspected abuse with the following staff person and residents:
Staff Person C to Resident 3.

15a - Resident Abuse Report (continued)

Staff Person D to Resident 4.
Staff Person D to Resident 5.
Staff Person D to Resident 1.
Former Staff Person B reported these concerns to Staff Person E on 05/15/2024 at 2:09PM via email. These concerns were not reported to the local Area Agency on Aging until 05/16/2024 at 2:00PM.

On 05/17/2024 at approximately 6:00PM, Resident 2 reported potential physical abuse by Staff Person F and G while staff were performing care on the resident. Resident 2 reported these concerns to Staff Person H. However, these allegations were not reported the local Area Agency on Aging.

Plan of Correction ***Accept ([redacted] - 08/07/2024)***

-All appropriate parties were notified regarding staff persons C, D, and B and residents 5,4,3,1 by Staff person E. Area Agency on Aging labeled this allegation unfounded. The incident with staff members F, G, and H was reported on 08/02/2024 by Harmony Square Director to the Area Agency on Aging.
-Administrator or Designee will educate Staff members C, D, F G, and H as well as managers on resident abuse and regulation 15a and regulation 42. B This will be completed by August 7, 2024.
-The Administrator will review and complete all reportable incidents for the next 3 months to ensure they are reported within compliance. This will begin on August 15, 2024. The Administrator will check in with the Director of Nursing during the morning meeting five days a week to identify any incidents that may have occurred for reporting purposes. The Director of Nursing will conduct daily reviews of the daily shift reports for each floor (3) total floors with the floor Medication Associate before the management morning meeting to observe for incidents to review at the morning management meeting with the Executive Director for reporting purposes. This will start on August 15th, 2024, and continue for 3 months.

Proposed Overall Completion Date: 11/15/2024

Licensee's Proposed Overall Completion Date: *11/15/2024*

16c - Written Incident Report

3. 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 05/14/2024 between the hours of 3:00PM-7:00PM, former Staff Person B observed suspected abuse with the following staff person and residents:
Staff Person C to Resident 3.
Staff Person D to Resident 4.
Staff Person D to Resident 5.
Staff Person D to Resident 1.

16c - Written Incident Report (continued)

Former Staff Person B reported these concerns to Staff Person E on 05/15/2024 at 2:09PM via email. These concerns were not reported to the Department until 05/16/2024 at 2:00PM.

On 05/17/2024, at approximately 8:00PM, former Staff Person I received a call from Staff Person A. Staff Person A reported that they received a call from a visitor in the building reporting suspected abuse of Resident 2 by Staff Person H. Staff Person H was suspended and an internal investigation was conducted. However, the home did not report the incident to the Department until 05/20/2024 at 10:50AM.
Furthermore, on 05/17/2024 at approximately 6:00PM, Resident 2 reported potential physical abuse by Staff Person F and G while staff were performing care on the resident. Resident 2 reported these concerns to Staff Person H. However, these allegations were not reported the Department.

Repeated Violation-11/07/2023, et al and 08/08/2023, et al

Plan of Correction ***Accept ([redacted] - 08/07/2024)***

-All appropriate parties were notified regarding staff persons C, D, and B and residents 5,4,3,1 by Staff person E. Area Agency on Aging labeled this allegation unfounded. The incident with staff members F, G, and H was reported on 08/02/2024 by Harmony Square Director to the Area Agency on Aging.
-Administrator or Designee will educate Staff members C, D, F G, and H as well as managers on resident abuse and regulation 15a and regulation 42. B This will be completed by August 7, 2024.
-The Administrator will review and complete all reportable incidents for the next 3 months to ensure they are reported within compliance. This will begin on August 15, 2024. The Administrator will check in with the Director of Nursing during the morning meeting five days a week to identify any incidents that may have occurred for reporting purposes. The Director of Nursing will conduct daily reviews of the daily shift reports for each floor (3) total floors with the floor Medication Associate before the management morning meeting to observe for incidents to review at the morning management meeting with the Executive Director for reporting purposes. This will start on August 15th, 2024, and continue for 3 months.

Proposed Overall Completion Date: 11/15/2024

Licensee's Proposed Overall Completion Date: *11/15/2024*

42b - Abuse

4. Requirements

2600.
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 05/14/2024, between the hours of 3:00PM-7:00PM, Staff Person D was feeding Resident 4. It is reported that the resident is visually impaired and suffers from confusion. It was reported by former Staff Person B, that Staff Person D "shoved a chicken tender into the resident's mouth without notice", causing the resident to be startled and combative.

42b - Abuse (continued)

Repeated Violation - 08/08/2023, et al

Plan of Correction ***Accept (- 07/31/2024)***

-Administrator or designee will Inservice staff person D on regulation 42.b and a different approach by August 3, 2024.
-The director of Nursing will complete 1 audit a week to assess and coach Staff member D. This will begin on August 7, 2024. Audits will be kept on file for department review. This will continue for 3 months.

Licensee's Proposed Overall Completion Date: *11/07/2024*

42c - Treatment of Residents

5. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 05/14/2024, between the hours of 3:00PM-7:00PM, the following incidents occurred:

Resident 3 stated to Staff Person C that another resident was taking off their shirt. Staff Person C told Resident 3 to "mind your own business."

Resident 5 stated to Staff Person D, "I need to go to the bathroom." Staff Person D refused to assist the resident to the restroom stating, "you don't need to go, you just went." Upon hearing this, former Staff Person B, assisted the resident to the restroom where urinated.

Resident 1 requested coffee. Staff Person D stated, "You don't drink coffee." The resident has no medical orders that cannot have coffee. Coffee was never brought to the resident, and no alternatives were offered to the resident.

Plan of Correction ***Accept (- 07/31/2024)***

All appropriate parties were notified regarding staff persons C, D, and B and residents 5,4,3,1 by Staff person E. Area Agency on Aging labeled this allegation unfounded.
- -Administrator or Designee will educate Staff members C, D,F G and H as well as managers on resident abuse and regulation 15a and regulation 42. B This will be completed by August 7, 2024.
-The director of Nursing will complete 1 audit a week on Staff members C and D to assess how care is given and interactions between staff and residents. The Director will document and keep it on file for department review. This will begin August 6 and continue for 3 months.

Licensee's Proposed Overall Completion Date: *11/06/2024*

42c - Treatment of Residents *(continued)*

51 - Criminal Background Check

6. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Former Staff Person B was hired [redacted] however, a Pennsylvania State Police criminal background check was not initiated until [redacted]

Plan of Correction ***Accept ([redacted] - 07/31/2024)***

-Administrator in-serviced the Business Office Manager on August 7 on regulation 51.
-Business Office Manager to complete Criminal Background check audit for compliance. This will be completed by August 23. The audit will be kept on file for review by the department.
-The administrator will initial and sign off on the new hire's criminal background check after completion of the audit on August 23. This will start on August 24 and continue for 3 months to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/23/2024*

65a - FS Orientation 1st Day

7. 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:

Description of Violation

Staff Person B, whose first day of work was [redacted], did not receive orientation on the following topics:
(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.

Plan of Correction ***Accept ([redacted] - 07/31/2024)***

-The administrator will complete an in-service with the Business Office Manager regarding Regulation 65a by August 7, 2024.
-The Business Office Manager will complete an audit for all first 40 hours of employee files to assess compliance by August 23.
-The Administrator is to sign off on all first 40 hours of training for new hires. This will begin after the audit on

65a - FS Orientation 1st Day (continued)

August 24 and continue for 3 months to maintain compliance. The documents will be filed for department review.

Licensee's Proposed Overall Completion Date: *11/24/2024*

65d - Initial Direct Care Training

8. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care Staff Person D, hired on [redacted], did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted]

Plan of Correction ***Accept ([redacted] - 07/31/2024)***

-The Business office manager will be in-serviced on regulation 65.d by the administrator by August 7,2024.
-The Direct Care course was completed on 05/27/2023. This was with previous management in place. The Business Office Manager will complete an audit by August 23, 2024, of all Clinical Associates and Direct Care course competency to maintain compliance with Regulation 65. A
-The business office manager will maintain a new hire spreadsheet with all hire dates and the date when the direct care staff has taken the competency test. This will begin on August 24, 2024, and continue for 3 months. [redacted] will audit after every orientation and initial the audit. This will be kept on file for department review.

Licensee's Proposed Overall Completion Date: *11/24/2024*

[redacted]

[redacted]

[redacted] 9/17/24 [redacted]

227d - Support Plan Medical/Dental

10. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for Resident 2, dated [redacted] indicates the resident has a need for a wheelchair and walker to self-propel. However, the resident's support plan, dated [redacted] does not document how this need will be met. Furthermore, the assessment indicates the resident needs assistance with ambulation and transferring in/out of bed/chair. However, the support plan does not document how this need will be met.

Plan of Correction ***Accept ([redacted] - 08/06/2024)***

-Director of Nursing in-serviced on regulation 227.d by August 7th and kept on file for department review.
- Director of Nursing updated the Assessment on resident 2 has been updated as of July 30th to show how the need was met to comply with regulation 227.d
- Director of Nursing to complete a spreadsheet for assessments as a second check for completion in all areas of documentation of the assessment. This is to start August 20th and continue for 3 months with all new assessments for compliance. The Administrator will review the spreadsheet weekly and initial. This will be kept on file for department review.

Licensee's Proposed Overall Completion Date: *11/20/2024*