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

June 3, 2025

[redacted]
COLUMBIA COTTAGE-HERSHEY LLC
[redacted]

RE: COLUMBIA COTTAGE-HERSHEY, LLC
103 N. LARKSPUR DRIVE
PALMYRA, PA, 17078
LICENSE/COC#: 33024

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/03/2025 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: *COLUMBIA COTTAGE-HERSHEY, LLC* **License #**: *33024* **License Expiration**: *05/02/2025*

Address: *103 N. LARKSPUR DRIVE, PALMYRA, PA 17078*

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

Administrator

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

Legal Entity

Name: *COLUMBIA COTTAGE-HERSHEY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/11/2000* **Issued By**: *Labor & industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *50* **Waking Staff**: *38*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Complaint, Incident* **Exit Conference Date**: *04/03/2025*

Inspection Dates and Department Representative

04/03/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *37*

Special Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*

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

Have Mobility Need: *13* **Have Physical Disability**: *1*

Inspections / Reviews

04/03/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/28/2025*

04/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/09/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/30/2025*

Inspections / Reviews *(continued)*

04/24/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/09/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/02/2025*

06/03/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/09/2025*

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

51 Criminal background checks

1. Requirements

2800.

51.a. 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).

51.b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Staff Person A started working at the home through an agency in January of 2022. Then Staff Person A was hired by the home on [redacted] *However, a criminal background check was not completed for Staff Person A.*

Plan of Correction ***Directed ([redacted] - 04/24/2025)***

Staff person A no longer works for the cottage. All staff files will be audited by 4/30/2025 by human resources and the administrative assistant. Any missing documents will be obtained and put into the staff file by 05/09/2025 by human resources and the administrative assistant. Human Resources and the Managing Director, or designee, will utilize the Employee File Checklist to ensure all documentation is received and marked off on the checklist. This checklist includes running and retaining a copy of the criminal background check. An Agency Orientation binder was created and all the required documents that need reviewed are added. The Managing Director or designee will conduct an orientation with agency staff prior to working. Moving forward, the Managing Director or the designee will obtain the checklist once the onboarding and training are completed and review it for completion. This audit will be ongoing. This ongoing audit will start with the next new hire or new agency staff person.

Human Resources, the administrative assistant and the managing director are responsible for compliance with this regulation. An email was sent to HR and the administrative assistant which includes the regulation and the process moving forward. The managing director is writing the plan of correction so is aware of how to be compliant.

Attached are the checklists that are mentioned in the plan of correction as well as the email that was sent to HR and the administrative assistant.

Proposed Overall Completion Date: 05/09/2025

[Directed]

- *Human Resources, the administrative assistant and the managing director are responsible for compliance with this regulation. On 4/23/254, an email was sent to HR and the administrative assistant which includes the regulation and the process moving forward.*
- *Beginning no later than 5/9/25, the Managing Director or designee will review all completed new hire checklists once the onboarding and training are completed to ensure compliance.*

Directed Completion Date: *05/09/2025*

Implemented [redacted] - 06/03/2025)

65a Fire Safety-1st day

2. Requirements

2800.

65a Fire Safety 1st day *(continued)*

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 Person A started working at the home through an agency in January of 2022. Then Staff Person A was hired by the home on [redacted] However, Staff Person A 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 ***Directed [redacted] - 04/24/2025)***

Staff person A no longer works for the cottage. All staff files will be audited by 4/30/2025 by human resources and the administrative assistant. Any missing documents will be obtained and put into the staff file by 05/09/2025 by human resources and the administrative assistant. All new cottage and agency staff are to complete the New Hire Orientation Training checklist that includes an orientation to fire safety and emergency preparedness. An Agency Orientation binder was created and all the required documents that need reviewed are added. The Managing Director or designee will conduct an orientation with agency staff prior to working. Moving forward, the Managing Director or the designee will obtain the checklist once the onboarding and training are completed and review it for completion. This audit will be ongoing. This ongoing audit will start with the next new hire or new agency staff person.

Human Resources, the administrative assistant and the managing director are responsible for compliance with this regulation. An email was sent to the HR department which includes the regulation and the process moving forward. The managing director is writing the plan of correction so is aware of how to be compliant.

Attached are the checklists that are mentioned in the plan of correction and the email sent to HR and the administrative assistant.

Proposed Overall Completion Date: 05/09/2025

65a Fire Safety 1st day (continued)

[Directed]

- *Human Resources, the administrative assistant and the managing director are responsible for compliance with this regulation. On 4/23/254, an email was sent to HR and the administrative assistant which includes the regulation and the process moving forward.*
- *Beginning no later than 5/9/25, the Managing Director or designee will review all completed new hire checklists once the onboarding and training are completed to ensure compliance.*

Directed Completion Date: *05/09/2025*

Implemented [redacted] - 06/03/2025)

65e Rights/Abuse 40 Hours

3. Requirements

2800.

65.e. 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.
2. Emergency medical plan.
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.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

Description of Violation

Staff Person A started working at the home through an agency in January of 2022. Then Staff Person A was hired by the home on [redacted]. Staff person A completed [redacted] 40th scheduled work hour. However, Staff Person A did not complete training in the following topics:

1. Resident rights.

2. Emergency medical plan.

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.

5. Safe management techniques.

6. Core competency training that includes the following:

i. Person centered care.

ii. Communication, problem solving and relationship skills.

iii. Nutritional support according to resident preference.

Plan of Correction ***Directed [redacted] - 04/24/2025)***

Staff person A no longer works for the cottage. All staff files will be audited by 4/30/2025 by human resources and the administrative assistant. Any missing documents will be obtained and put into the staff file by 05/09/2025 by human resources and the administrative assistant. All new cottage and agency staff must complete the New Hire Orientation Training checklist that includes all required topics in Regulation 65e. An Agency Orientation binder

65e Rights/Abuse 40 Hours (continued)

was created and all the required documents that need reviewed are added. The Managing Director or designee will conduct an orientation with agency staff prior to working. Moving forward, the Managing Director or the designee will obtain the checklist once the onboarding and training are completed and review it for completion. This audit will be ongoing. This ongoing audit will start with the next new hire or new agency staff person.

Human Resources, the administrative assistant and the managing director are responsible for compliance with this regulation. An email was sent to the HR department which includes the regulation and the process moving forward. The managing director is writing the plan of correction so is aware of how to be compliant.

Attached are the checklists that are mentioned in the plan of correction and the email that was sent to HR and the administrative assistant.

Proposed Overall Completion Date: 05/09/2025

[Directed]

- *Human Resources, the administrative assistant and the managing director are responsible for compliance with this regulation. On 4/23/254, an email was sent to HR and the administrative assistant which includes the regulation and the process moving forward.*
- *Beginning no later than 5/9/25, the Managing Director or designee will review all completed new hire checklists once the onboarding and training are completed to ensure compliance.*

Directed Completion Date: *05/09/2025*

Implemented [redacted] 06/03/2025)

132a Monthly fire drill

4. Requirements

2800.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The fire drills conducted on [redacted], at 5:02 AM, and [redacted], at 5:02 AM, were announced. Staff reported the residents' wheelchairs and Hoyer lifts were all positioned and ready outside the residents' doors prior to the fire alarm being pulled. In addition, during the [redacted] fire drill, a resident's family member was present and assisting [redacted] spouse to evacuate to the fire safe areas.

Plan of Correction ***Directed [redacted] 04/24/2025)***

The Managing Director created a new schedule for fire drills provided the schedule to the maintenance director on 04/22/2025. The new schedule for drills will start in May 2025. If family members are in the building, staff will instruct them not to help evacuate. Staff will be educated on the fire/emergency evacuation protocol and documentation of that training will be obtained by 05/09/2025. Fire drills will continue to be held monthly according to DHS regulations. The education provided to the staff, including the maintenance team, will include the following: fire drills may not be announced, family members cannot be contacted beforehand, and no equipment may be

132a Monthly fire drill (continued)

prepped. The Managing Director will provide this training by 05/09/2025. The Managing Director will review the fire drill and interview staff members to ensure staff had no prior knowledge, families were unaware, and equipment was not prepped. There is a document on which the fire drill is documented, and a column will be added for the Managing Director to report that the staff were interviewed. This will start with the May fire drill.

Attached is the new fire drill schedule that was mentioned in the plan of correction and the fire drill observation form.

Proposed Overall Completion Date: 05/09/2025

[Directed]

- *Beginning no later than 5/9/25, the Managing Director will review the fire drill and interview staff members to ensure staff had no prior knowledge, families were unaware, and equipment was not prepped. There is a document on which the fire drill is documented, and a column will be added for the Managing Director to report that the staff were interviewed. This review will be monthly and will start with the May fire drill.*

Directed Completion Date: *06/01/2025*

Implemented ([redacted] - 06/03/2025)

132d Evacuation

5. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

The residence has a maximum safe evacuation time of 15 minutes and 00 seconds specified in writing within the past year by a fire safety expert. The residence exceeded this maximum evacuation time during the fire drill on [redacted] at 5:02 AM, which had a total evacuation time of 19 minutes 26 seconds.

Plan of Correction ***Directed [redacted] - 04/24/2025)***

The maintenance director or designee will educate staff on the fire/emergency evacuation protocol. Documentation of that education and a sign-in sheet with staff signatures will be obtained by 05/09/2025. If the fire drill fails, the Managing Director will coordinate with maintenance to conduct it again. A new fire drill schedule was completed and given to the maintenance director for all drills for the rest of the year. The root causes of the failed fire drill were multiple residents using the restroom or getting care from the nursing staff. There were two newer staff members that it was their first drill and were not as experienced with the process. The Managing Director will observe fire drills and assess the fire drills. After the fire drill is over, the staff involved will get together and review the drill and look at areas of improvement and success. This review will be documented on the Fire Drill Observation Evaluation Form, which is attached. This will start with the May fire drill.

Attached are the fire drills and evac protocol document that was mentioned in the plan of correction. Also attached is the new fire drill schedule mentioned in the plan of correction.

132d Evacuation (continued)

Proposed Overall Completion Date: 05/09/2025

[Directed]

- *Beginning no later than 5/9/25, the Managing Director will observe fire drills and assess the fire drills when they occur. After the fire drill is over, the staff involved will get together and review the drill and look at areas of improvement and success. This monthly review will be documented on the Fire Drill Observation Evaluation Form, which is attached. This will start with the May fire drill.*

Directed Completion Date: *06/01/2025*

Implemented [redacted] - 06/03/2025)

225a2 Assessment – significant change

6. Requirements

2800.
225.a.2. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On [redacted], Resident [redacted] was prescribed a Hoyer lift for transfers. However, Resident [redacted] current assessment, dated [redacted], does not include the resident utilizes a Hoyer lift.

Resident [redacted] was initially diagnosed with a wound on [redacted]. Since then, the resident has been receiving treatment for [redacted] wounds. Also, Resident [redacted] utilizes a trapeze bar to aid in repositioning. However, Resident [redacted] current assessment, dated [redacted] does not include the resident has wounds, is receiving on-going wound treatment or that the resident utilizes a trapeze bar.

Plan of Correction ***Directed [redacted] - 04/24/2025)***

The Resident Services Director immediately updated Resident [redacted] ASP to include the Hoyer lift. The Resident Services Director updated Resident [redacted]s ASP to include the use of the trapeze bar and wound treatment immediately. The Resident Services Director will audit all ASPs for residents with any mobility device (Hoyer lift, sit-to-stand lift, trapeze bar, enabler bars, etc.) and ensure the use is documented on the ASP. The Resident Services Director will also audit the residents' ASPs who currently have active wound care or treatment and ensure that it is noted on their ASPs. These two audits will be completed by 05/09/2025. The Resident Services Director and Managing Director will audit and review all residents' ASPs to ensure they reflect the care required properly. This audit will be done monthly for three months, starting in May. The Resident Services Director or Managing Director will educate staff on the proper protocol of reporting changes in residents and their needs and documentation of that training will be obtained by 05/09/2025.

Proposed Overall Completion Date: 05/09/2025

225a2 Assessment – significant change (continued)

[Directed]

- *Beginning no later than 5/9/25, the Resident Services Director and Managing Director will audit and review all residents' ASPs to ensure they reflect the care required properly. This audit will be done monthly for three months, starting in May.*

Directed Completion Date: *05/09/2025*

Implemented [redacted] 06/03/2025)