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

July 2, 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 05/13/2025 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 and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *47* **Waking Staff**: *35*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *05/13/2025*

Inspection Dates and Department Representative

05/13/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *35*

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**: *35*

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

Have Mobility Need: *12* **Have Physical Disability**: *1*

Inspections / Reviews

05/13/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/14/2025*

06/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/01/2025*

Inspections / Reviews *(continued)*

07/02/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/01/2025*

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

23a ADL assistance

1. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, updated on [redacted], for resident [redacted], indicates the resident requires total assistance with hygiene practices surrounding toilet use and indicates two staff members will assist [redacted] with hygiene practices surrounding toilet use, additionally the plan indicates that the resident is incontinent of bladder and bowel, wears protection and will ring [redacted] call bell for staff to assist in using the bathroom. On [redacted] the assessment and support plan was updated to include wound care that was being provided to resident [redacted] as a result of a pressure ulcer on the resident's sacrum. At this time, the home placed resident [redacted] on two hour incontinence checks to be completed by staff. On [redacted] at 7:00 AM, staff member A observed that resident [redacted] was wearing a soiled undergarment that had been dated earlier in the shift and had not been checked or changed per the 2 hour requirement. The resident was observed to have an excoriated groin area and an open wound on [redacted] sacrum.

Plan of Correction ***Accept [redacted] - 06/12/2025)***

The Staff Member who failed to adhere to the every two-hour toileting requirement was terminated by Human Resources on 04/11/2025.

Staff Member A and all staff members assigned to Resident [redacted] were promptly re-educated on Resident [redacted] ASP, including the requirement for two-person assist and two-hour incontinence checks. The re-education was conducted by the Resident Services Director (RSD) and Managing Director (MD) and was completed on 04/10/2025.

Resident [redacted] received incontinence care every two hours per the tasks documented in point click care after staff member A reported the incident to the RSD and MD. See Meyers POC Tasks attached

On 04/11/2025, the RSD and MD reviewed Resident [redacted]s ASP and the tasks listed in Point Click Care to ensure alignment. At that time, a task was in place requiring nursing staff to complete two-hour toileting and document completion once per shift. On 04/27/2025, the task was revised to require documentation each time toileting is performed, rather than once per shift. Refer to the attached Meyers POC Tasks.

The RSD and MD will conduct an in-service training on June 25, 2025, for all direct care staff, covering resident ADLs, ASPs, best practices in incontinence care, documentation standards, and accountability for two-hour checks. All staff will be required to complete the training and sign acknowledgment of the education by July 18, 2025. Refer to the attached agenda.

23a ADL assistance (continued)

As of 05/29/2025, all nursing staff will be required to document walking rounds to verify that residents have received the care outlined in their ASPs. Walking rounds documentation must be completed by both oncoming and offgoing staff and submitted to the RSD following the completion of each round.

Effective 06/05/2025, the RSD will begin reviewing POC documentation to ensure all tasks are completed and appropriately signed off. The schedule for these reviews is as follows:

06/05/2025 – 08/01/2025: Reviews will be conducted three days per week.
08/02/2025 – 10/01/2025: Reviews will be conducted twice per week.
10/02/2025: Reviews will transition to once per week.

The Monday review will include checking documentation from Friday, Saturday, and Sunday. All other reviews will focus on the previous day's documentation for completeness. The RSD will record completion of these checks on the POC Documentation Review document. If any documentation is found to be missing, the RSD will verify that the task was completed by contacting the assigned staff member and will provide a re-education session using the POC Task Re-Education document. If a staff member has repeated instances of missed documentation, documented corrective actions or write-ups will follow.

Licensee's Proposed Overall Completion Date: *07/18/2025*

Implemented [redacted] - 07/02/2025)

60b - Additional Staffing

2. Requirements

2800.
60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

Description of Violation

The home has 35 residents including 12 with mobility needs that require assistance evacuating in the event of an emergency. On [redacted] from 11:15 PM until [redacted] at 6:00 AM, there were only 2 direct care staff working in the residence. Based on the size of the building and the population served, more than 2 staff with direct care training need to be present to ensure that the residents' needs can be met and that all residents can be safely evacuated in the event of an emergency.

Plan of Correction ***Accept ([redacted] - 06/12/2025)***

The RSD and MD reviewed the staffing schedule immediately following the inspection to confirm that at least three direct care staff members are scheduled for all overnight shifts. A fourth direct care staff member has been added to most overnight shifts to enhance coverage. Moving forward, when the RSD prepares the schedule, the third shift will operate with no fewer than three direct care staff members.

To ensure continued compliance with minimum staffing requirements, the Managing Director or designee will

60b - Additional Staffing (continued)

review the weekly staffing schedules. This audit will begin on 06/05/2025 and conclude on 08/01/2025. Audits will be documented on the attached Weekly Staffing Schedule Audit form.

Staffing levels and compliance will be a standing agenda item in monthly Quality Management meetings to ensure ongoing review and adjustment based on resident needs.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented [redacted] 07/02/2025)

183b Medications and syringes locked

3. Requirements

2800.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

On [redacted], the following prescription medications were unlocked and accessible to resident [redacted] in the resident's nightstand: a tube of [redacted]; a tube of [redacted]; and a tube of [redacted]. Resident [redacted] is not assessed to self-administer medications.

Plan of Correction ***Accept [redacted] - 06/12/2025)***

Upon discovery, the unsecured medications were immediately removed from the resident's nightstand by the RSD and properly secured in the designated medication or treatment carts, in accordance with policy. The POA and staff were verbally re-educated on the policy by the RSD.

The MD will complete a comprehensive resident room audit to ensure there are no unsecured medications in resident rooms. This audit will be documented on the Initial Resident Room Audit form and completed by 06/20/2025.

Starting 06/30/2025, the MD will select at least 10 resident rooms each week to audit for unsecured medications. Different rooms will be audited each week through the week of 07/28/2025. The schedule is outlined on the attached Resident Room Audit.
Beginning in August, the MD will conduct room audits monthly for August, September, and October. All the resident rooms will be audited within the three months. The attached Monthly Resident Room Audit includes the rooms and months of their audit.

The MD/RSD will conduct an in-service training on June 25, 2025, for all direct care staff covering medication self-administration policies and regulations. All staff must complete the training and sign off on the education by July 16, 2025. Please refer to the attached June Staff Meeting Agenda.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented [redacted] - 07/02/2025)

187a Medication record

4. Requirements

2800.

187a Medication record *(continued)*

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

1. Resident's name.

Description of Violation

On [redacted], the medication administration records (MARs) indicate that staff member C administered resident [redacted], [redacted], and [redacted], however, staff member C stated that they marked the MAR on behalf of another staff who actually administered these medications to the resident.

Resident [redacted] was prescribed [redacted], give 1 tablet by mouth one time a day for 8 days. This medication is marked as given from [redacted] through [redacted] which is a 9 day span.

Resident [redacted] was prescribed [redacted] to be administered twice a day. This medication was marked as given the morning of [redacted] even though it wasn't available the evening of [redacted] or [redacted] and therefore could not have been administered.

Plan of Correction ***Accept [redacted] - 06/12/2025)***

Staff were immediately verbally re educated by the RSD and MD regarding the policy that only Med Techs and LPNs are permitted to administer any type of prescription medication or medicated cream.

The MD/RSD will conduct an in service training on June 25, 2025, for all direct care staff, which will include a review of DHS Regulation 182(a)(b) Medication Administration. All staff must complete the training and sign off on the education by July 16, 2025. Please refer to the attached June Staff Meeting Agenda.

The staff member who incorrectly entered the order was immediately re educated by the RSD and MD on the importance of double checking order entries and utilizing the automatic end date feature in PCC. This feature ensures the order's end date is properly calculated based on the length of the order entered.

All LPNs and Coordinators will participate in an order entry retraining session on June 25, 2025, provided by the Regional Staff Development Manager. All LPNs and Coordinators must complete the training and sign off on the education by July 16, 2025.

The Resident Wellness Directors will complete a comprehensive medication cart audit to verify that all medications listed on the MAR are present in the medication carts. This audit will be completed by 06/20/2025 using the attached Medication Cart Audit form.
Starting in July, third shift staff will perform monthly medication cart audits, also utilizing the Medication Cart Audit form. Completed audit forms will be submitted to the MD for review and follow up on any necessary corrections.

The MD/RSD will conduct an in service training on June 25, 2025, for all LPNs, Coordinators, and Med Techs. The training will cover the following topics: The importance of reordering medications before the supply is exhausted, immediate reordering of medications from the pharmacy if a medication is not on hand and the requirement to immediately report any missing medications to the Coordinator or LPN. See attached LPN/Coordinator/Med Tech Meeting agenda.

Licensee's Proposed Overall Completion Date: *07/16/2025*

187a Medication record *(continued)*

Implemented [redacted] - 07/02/2025)

187d Follow prescriber's orders

5. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] was prescribed [redacted] to be administered twice a day. This medication was not administered to resident [redacted] from the evening of [redacted] through the evening of [redacted] because it was not available in the residence.

Plan of Correction ***Accept [redacted] - 06/12/2025)***

Staff were immediately verbally re-educated by the RSD and MD on the importance of reordering medications timely and the policy prohibiting staff from signing off on the MAR for medications that have not been administered.

The MD/RSD will conduct an in-service training on June 25, 2025, for all LPNs, Coordinators, and Med Techs. The training will include reordering medications before the supply is exhausted, immediate reordering of medications from the pharmacy if a medication is not on hand and immediate reporting of unavailable medications to the Coordinator or LPN. All staff must complete the training and sign off on the education by July 16, 2025. See attached LPN/Coordinator/Med Tech Meeting Agenda.

The Resident Wellness Directors will conduct a comprehensive medication cart audit to verify that all medications listed on the MAR are present in the medication carts. This audit will be completed by 06/20/2025 using the attached Medication Cart Audit form.
Beginning in July, third shift staff will perform monthly medication cart audits. Completed audit forms will be submitted to the MD for review and follow-up on any necessary corrections.

Licensee's Proposed Overall Completion Date: *07/16/2025*

Implemented [redacted] - 07/02/2025)