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

March 2, 2026

[redacted]
GAHC3 PALMYRA PA ALF TRS SUB LLC
[redacted]
C/O HERITAGE SENIOR LIVING
[redacted]

RE: TRADITIONS OF HERSHEY
100 NORTH LARKSPUR ROAD
PALMYRA, PA, 17078
LICENSE/COC#: 33260

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/29/2025, 12/30/2025 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: *TRADITIONS OF HERSHEY* **License #**: *33260* **License Expiration**: *02/01/2026*

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]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/29/2018* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *37* **Waking Staff**: *28*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *12/30/2025*

Inspection Dates and Department Representative

12/29/2025 - On-Site: [redacted]

12/30/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *30*

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

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

12/29/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/30/2026*

02/02/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/27/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/06/2026*

Inspections / Reviews *(continued)*

02/09/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/27/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/01/2026*

03/02/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/27/2026*

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

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On [redacted] the Halo mobility device affixed to Resident [redacted] bed was loose, moving 6 to 12 inches when pressure was applied posing a safety hazard.

On [redacted] the Halo mobility device affixed to Resident [redacted]s bed was loose, moving 6 to 12 inches when pressure was applied posing a safety hazard.

Plan of Correction ***Accept [redacted] - 02/02/2026)***

Immediate Action: Halo bar was removed from resident [redacted]s bed on 1/2/2026 by the Maintenance Director. The Halo bar was tightened on resident [redacted]s bed by Maintenance Director on 12/30/2025. On 1/27/2026 Resident [redacted] decided to utilize a hospital bed and will no longer need a Halo bar. Halo bar was removed by the Maintenance Director and hospital bed was ordered by the Resident Care Director. Expected delivery of hospital bed is 1/30/2026. Hospital bed will be checked to meet all requirements by the Resident Care Director upon its arrival.
Additional Corrective Action: Resident [redacted] educated about the risks of using a Halo bar on 1/27/2026 by Resident Care Director. Resident [redacted]s RASP was updated by the Resident Care Director on 1/27/2026 to reflect the change from utilizing the Halo to a hospital bed. An audit was completed of all personal care resident rooms to confirm no rooms had bedside mobility devices on 1/26/2026 by the Executive Director.
Ongoing Corrective Action: Beginning 2/9/2026 quarterly audit of mobility devices to be completed by the Executive Director. No other devices have been found. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/09/2026*

Implemented [redacted] - 03/02/2026)

82a - Poisonous Materials

2. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On [redacted] at 9:29 AM, an unlabeled spray bottle containing a blue liquid was observed in a housekeeping cart; the administrator was unable to identify the liquid.

Plan of Correction ***Accept [redacted] - 02/02/2026)***

Immediate Action: On 12/30/2025 the unidentifiable liquid was removed by the Executive Director.

82a Poisonous Materials (continued)

Additional Corrective Action: All housekeeping team members to be educated by the Maintenance Director on 1/30/2026 on the regulatory compliance of liquids being in the labeled and original containers. All carts were audited and housekeepers were trained by Maintenance Director to ensure all poisonous materials are in their original labeled containers on 1/30/2026.
Ongoing Corrective Action: Beginning 2/2/2026, Maintenance Director will complete a daily walk through the Personal Care neighborhood to ensure all poisonous containers are stored in their original labeled containers. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/02/2026*

Implemented (03/02/2026)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On at approximately 10:45 AM, Resident bathroom had a strong odor of urine and urine was observed dripping from the toilet seat to the floor. On at 3:15 PM, Resident bathroom continued to have a strong odor of urine and a dark yellow/brown stain on the floor surrounding the toilet, urine on and around the toilet bowl, and feces present on the shower chair.

Plan of Correction ***Accept - 02/06/2026)***

85a) Immediate Action: On 12/30/2025 the housekeeping team cleaned the bathroom.
Additional Corrective Action: On 1/30/2026, the Maintenance Director educated Housekeeping team on sanitary regulations, HSL standards and infection prevention processes. By 2/13/2026 all team members (Medication Technicians and Caregivers) that enter rooms daily will be educated that if any area of Personal Care is to be found unclean or have odors, the team member must place a work order to have it remedied.
Ongoing Corrective Action: Beginning on 2/2/2026 the housekeepers will fill out the apartment cleaning checklist each week they clean resident's rooms. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/13/2026*

Implemented - 03/02/2026)

103c - Food Protected

4. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On at 3:01 PM, there were uncovered containers of pre prepped salad toppings stored in the walk in refrigerator in the kitchen.

Plan of Correction ***Accept - 02/02/2026)***

Immediate Action: On 12/30/2025 the uncovered food containers on the salad bar were disposed of by Dining

103c - Food Protected (continued)

Services Director and new items were prepared for the next meal.
Additional Corrective Action: On 12/30/2025 the Dining Services Director provided education to the dining staff for proper food storage. A daily audit was completed from 1/1-1/6/2026 by the Dining Services Director and Lead Cook. A weekly audit was completed on 1/12/2026, 1/19/2026, 1/26/2026 by the Dining Services Director and Lead Cook.
Ongoing Corrective Action: Beginning on 1/28/2026 the Dining Services Director will use the daily food service log to ensure salad bar items are properly stored. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/02/2026*

Implemented [redacted] - 03/02/2026)

103d - Storing Food Off Floor

5. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On [redacted] at 3:03PM, a 5 lb. chub of ground beef was stored in a bin on the floor of the walk-in freezer.

Plan of Correction ***Accept [redacted] 02/02/2026)***

Immediate Action: On 12/30/2025 the 5lb ground beef in the container on the floor of the walk-in freezer was disposed of by the Dining Services Director
Additional Corrective Action: On 12/30/2025 the Dining Services Director provided education to the Dining Services team on not storing food on the floor. A daily audit was completed from 1/1-1/6/2026 by the Dining Services Director and Lead Cook. A weekly audit was completed on 1/12/2026, 1/19/2026, 1/26/2026 by the Dining Services Director and Lead Cook.
Ongoing Corrective Action: Beginning on 1/28/2026 the Dining Services Director will use the daily food service log to ensure items are properly stored off the floor. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/02/2026*

Implemented [redacted] - 03/02/2026)

132e - Fire Drill Sleeping Hours

6. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on [redacted] at 6:04 AM. The previous sleeping hours fire drill was conducted on [redacted]

Plan of Correction ***Accept ([redacted] - 02/02/2026)***

Immediate Action: On 12/20/2025 the Executive Director reviewed regulation for overnight Fire Drills with the Maintenance Director.
Additional Corrective Action: The Maintenance Director will build out the yearly fire drill scheduled by 2/6/2026 to

132e - Fire Drill Sleeping Hours (continued)

ensure the overnight fire drills are held during sleeping hours every 6 months. The schedule will be based on the date of the previous drill to ensure regulatory compliance.
Ongoing Corrective Action: Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] - 03/02/2026)

183d - Prescription Current

7. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], the following medications prescribed to Resident [redacted] were present in the medication cart, but were discontinued on [redacted]: [redacted], and [redacted].

Plan of Correction ***Accept [redacted] 02/02/2026)***

Immediate Action: On 12/30/2025 the following items for Resident [redacted] were removed from cart by Resident Care Director, Calcitriol .25mcg, Calcium Carbonate 500mg, Ergocalciferol (Vitamin D2) 1.25mg and Furosemide (Lasix) 40mg.
Additional Corrective Action: The Resident Care Director will provide education to med-techs by 2/6/26 on discontinued medications. Beginning 2/6/2026 the med-techs will use the weekly cart audit tool to ensure discontinued medications are removed from the medication cart at the time they are discontinued.
Ongoing Corrective Action: Beginning on 3/2/2026 Resident Care Director will review cart audit sheets monthly to ensure completion. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented [redacted] - 03/02/2026)

185a - Implement Storage Procedures

8. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] is prescribed [redacted] as needed. On [redacted] this medication was not available in the home.

Resident [redacted] is prescribed blood glucose checks 3 times a day, before meals. On [redacted] at 8AM, the glucometer reading was [redacted] however Resident [redacted] December 2025 Medication Administration Record indicated the blood glucose was [redacted].

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept [redacted] 02/02/2026)***

Immediate Action: [redacted] was ordered and available to resident [redacted] upon [redacted] return to the community on 1/23/2026.
Resident [redacted]s MAR was reviewed against glucometer to ensure glucometer and MAR matched by Resident Care Director on 1/2/2026.
Additional Corrective Action: Resident Care Director educated Lead Medication Technician to complete Shift Change Checklist. This will include medications being available in the cart to give and glucometer audits to ensure numbers are correctly documented in the residents MAR. By 2/13/2026 all Med Techs will be educated by the Resident Care Director and Lead Med Tech and will be using the Med Tech Shift Change Checklist.
Ongoing Corrective Action: Beginning on 2/16/2026 Resident Care Director will be responsible for reviewing and auditing Shift Change checklists and weekly cart audits to ensure completion and the glucometer audit. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 03/02/2026)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

On [redacted] Resident [redacted] was prescribed [redacted] q twice daily for 5 days and then [redacted] twice daily thereafter. This medication was not administered to Resident [redacted] from [redacted] through [redacted] as the medication was not available in the home.

On [redacted] a physician's order was received for Resident [redacted] to discontinue the following medications: [redacted], and [redacted] however, these medications continued to be administered until [redacted]

Resident [redacted] was prescribed [redacted] SS 4 times daily- if blood glucose is [redacted] inject [redacted] sub-q; [redacted] call MD.
On [redacted] at 5:00 PM, Resident [redacted] blood glucose was [redacted] The resident's August 2025 Medication Administration Record (MAR) indicated 0 units were administered; however, [redacted] should have been administered.
On [redacted] at 8:00 PM, Resident [redacted] blood glucose was [redacted] The resident's August 2025 MAR indicated [redacted] were administered; however, [redacted] should have been administered.
On [redacted] at 12:00 PM, Resident [redacted] blood glucose was [redacted]. The resident's August 2025 MAR indicated [redacted] were administered; however, [redacted] should have been administered.
On [redacted] at 8:00 PM, Resident [redacted] blood glucose was [redacted] The resident's August 2025 MAR indicated [redacted] were administered; however, [redacted] should have been administered.

Repeated Violation - [redacted]

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept [redacted] - 02/06/2026)***

187d) Immediate Action: Medication errors were reported for resident [redacted] on 8/28/2025 to DHS by Executive Director. Reportable submitted for errors for resident [redacted] on January 30th by the Executive Director, following resident refusal to comply with all medication changes ordered in their hospital discharge, and subsequent conversations with the primary care physician to reach an agreement between the physician and the resident as to what the orders would be.

Additional Corrective Action: Executive Director to educate Resident Care Director on 1/29/2026 verifying discharge orders with the pharmacy and primary physician when someone returns from the hospital. An audit is to be completed by the Resident Care Director by 2/27/2026 to ensure all medications are available to residents. Med-Techs will be re-educated by the Resident Care Director and Medication Trainer on the 5 rights of medication administration and 3 checks, including verification of sliding scale insulin doses, by 2/27/2026. An additional MAR review to be completed by Medication Trainer by 2/27/2026. Beginning on 2/27/2026, Med Techs will review glucometer readings during shift report using the shift change responsibility tool. The shift change responsibility tool includes but is not limited to a checklist and discussion of medications that need to be reordered, reviewing insulin administration against the MAR, glucometer verifications, and blood sugar checks, and will be completed at every shift change. Team members to be reeducated by the Resident Care Director by 2/27/2026 to read discharge orders and seek clarification to the prescriber. If a resident refuses a medication change, they must escalate the concern to the physician and reach out to the Resident Care Director. Beginning on 2/27/2026, daily Morning Huddles will be conducted by the Executive Director to review any hospital discharge instructions and any order changes with the Resident Care Director, as well as to discuss any concerns noted from SMART Dashboard reviews each day. Beginning 2/27/2026, the SMART dashboard will be checked daily by the Resident Care Director to monitor medication administration, appropriate administration of insulin per physician orders for sliding scale doses, and to see if there are any missed medications and report immediately.

Ongoing Corrective Action: Beginning on 2/27/2026, the Resident Care Director will audit a sample of 3 shift change responsibility tools weekly to ensure staff are completing all items assigned for review. Findings will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026. Discharge orders and changes will be discussed at Clinical Huddles beginning on 2/2/2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 03/02/2026)

190c - Record of Training

10. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for Staff Members A and B did not include a completed Initial Summary and Qualification User Report

190c - Record of Training *(continued)*

Plan of Correction ***Accept [redacted] - 02/02/2026)***

Immediate Action: On 1/7/2026 Med Tech trainer placed a ticket with MATP's to have access to all Med Tech files for Traditions of Hershey. Team members have been pulled to caregiver roles until online class is completed.
Additional Action: An audit of all Med Tech files to be completed by Med Tech Trainer by 2/13/2026 to ensure all training records are in Med Tech files.
Ongoing Action: Beginning on 2/6/2026 a 5% audit of Med Tech files will be completed monthly by the Business Office Director to ensure all training records are included in staff files. The Med Tech Trainer has made a spreadsheet on the dates that MAR reviews and observations must be completed by. Beginning on 2/6/2026 the Resident Care Director will do a monthly review. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/13/2026*

Implemented [redacted] - 03/02/2026)

225c - Additional Assessment

11. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted] assessment, completed on [redacted], indicated Resident [redacted] is on a regular diet with thin liquids. However, an order was received by the physician on [redacted] for no added sodium diet. The resident's assessment was not updated to reflect the resident's service need in this area.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] 02/02/2026)***

Immediate Action: On 1/20/2026 the Resident Care Director completed Resident [redacted]s annual care plan and updated the RASP to include the physicians order for no added sodium to the resident's diet. Beginning on 2/2/2026 any dietary changes are given to Dining Services Director at our morning huddle by the Resident Care Director.
Additional Action: The Resident Care Director will complete an audit all resident RASPs to ensure correct dietary needs are documented by 2/13/2026. Changes to resident care needs and diets will be discussed at our daily huddles and RASP's will be updated following the review.
Ongoing Action: Beginning on 2/2/2026 the Resident Care Director will audit a 5% sample of RASP's monthly, to ensure residents' care needs are appropriately documented. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/13/2026*

Implemented [redacted] - 03/02/2026)

227d - Support Plan Medical/Dental

12. 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

Resident [redacted] support plan, dated [redacted] indicated the resident's use of a Halo Safety Ring. However, the support plan does not reflect the specific need for the device, any risks associated, the resident's ability to use the device safely, or if a cover is required.

Plan of Correction ***Accept [redacted] - 02/02/2026)***

Immediate Action: On 1/27/2026 Resident [redacted] was educated by the Resident Care Director on the specific need for the Halo device and risks associated while using device. On 1/27/2026 the Halo was removed from bed by the Maintenance Director.

Additional Action: On 1/27/2026 all resident rooms were checked by the Executive Director to ensure no mobility devices were on beds without proper education and documentation. No devices were found. On 1/29/2026 the Executive Director educated the Resident Care Director and Maintenance Director on the regulatory requirements and HSL policy regarding bedside mobility devices.

Ongoing Action: The Resident Care Director will audit a 5% sample of resident rooms monthly beginning on 2/9/2026 to check for bed enabler devices and confirm device(s) are properly installed, residents have been educated to risks of device(s), HSL Policy and regulatory compliance and appropriately documented in residents care plan. Ongoing compliance will be discussed at quarterly Quality Assurance meetings beginning on 4/20/2026.

Licensee's Proposed Overall Completion Date: *02/09/2026*

Implemented [redacted] - 03/02/2026)