

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

# CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to TITHONUS CHAMBERSBURG, LP  
LEGAL ENTITY

To operate MAGNOLIAS OF CHAMBERSBURG - BUILDING 1  
NAME OF FACILITY OR AGENCY

Located at 735 NORLAND AVENUE, CHAMBERSBURG, PA 17201  
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE \_\_\_\_\_ ADDRESS OF SATELLITE SITE \_\_\_\_\_

ADDRESS OF SATELLITE SITE \_\_\_\_\_ ADDRESS OF SATELLITE SITE \_\_\_\_\_

ADDRESS OF SATELLITE SITE \_\_\_\_\_ ADDRESS OF SATELLITE SITE \_\_\_\_\_

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 26  
(MAXIMUM CAPACITY)  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 26

This certificate is granted in accordance with the Public Welfare 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 April 20, 2010 until April 20, 2011,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 307670

*Robert E. Robinson*

ISSUING OFFICER

*Kevin T. Casey*

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.

PW 628 - 4/02



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
PO BOX 2675  
HARRISBURG, PENNSYLVANIA 17105-2675

ADULT RESIDENTIAL LICENSING

APR 21 2010

PHONE: (717) 783-3670  
FAX: (717) 783-5662

Ms. Loriann Putzier, Executive Vice Pres.  
Tithonus Chambersburg, LP  
C/O Integracare Corp.  
6600 Brooktree Court, Suite 1000  
Wexford, Pennsylvania 15090

RE: Magnolias of Chambersburg – Building I  
735 Norland Avenue  
Chambersburg, Pennsylvania 17201

Dear Ms. Putzier:

As a result of the Department of Public Welfare's licensing inspection on December 18, 2009 of the above personal care home, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Violation Report were found.

All violations specified on the enclosed Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Adult Residential Licensing so that compliance can be verified.

A regular license is being issued based on the enclosed Violation Report. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Kevin T. Casey".

Kevin T. Casey  
Deputy Secretary

Enclosures  
License  
Violation Report

**VIOLATION REPORT  
PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

<b>NAME AND ADDRESS OF PERSONAL CARE HOME</b> Magnolias of Chambersburg Building 1 735 Norland Avenue Chambersburg, PA 17201		<b>CURRENT LICENSE NUMBER</b>  307670	
<b>INSPECTION DATE(S) (Include all dates of the inspection)</b> December 18, 2009		<b>REGIONAL REPRESENTATIVE</b> Jaime Erb, Lynn Loudenslager	
<b>SIGNATURE OF LEGAL ENTITY</b> <i>Genick</i>	<b>DATE</b> 2/8/10	<b>REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION</b> <i>[Signature]</i>	<b>DATE</b> 3/17/10


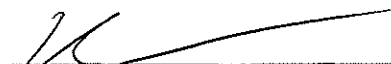
1 REGULATION 55 Pa.Code § 2600.	2 VIOLATION	3 DATE BY WHICH CORRECTION WILL BE COMPLETED	4 PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	5 DATE COMPLIANCE VERIFIED BY DPW
<p>22a1, 224a</p> <p>22a1 The following admission document shall be completed for each resident - Preadmission screening completed prior to admission on a form specified by the Department.</p> <p>224a 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.</p> <p align="right">PCH Division Central Region Field Office</p>	<p>Resident #1, admitted 12/8/09, has a preadmission screening dated 12/9/09.</p> <p>Repeated Violation: 8/11/08</p>	2/5/10	<p>1. The Executive Director conducted an audit of residents in building 1 and determined that one additional pre-admission assessment although completed was not signed was not for a resident admitted 1/14/04. A pre-admission screen was completed and signed on 2/5/10 by the Executive Director and placed in the resident file.</p>	4/13/10 <i>CB</i>

FEB 17 2010

**RECEIVED**

**VIOLATION REPORT  
PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**



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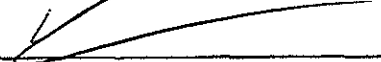
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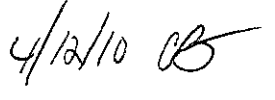
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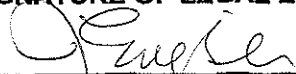

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22a4, 227a  22a4 The following admission document shall be completed for each resident - Support plan developed and implemented within 30 days after admission.  227a A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.	The home did not complete a support plan for Resident #2, admitted 11/6/09 and Resident #3, admitted 9/30/09.	1/6/10  12/31/09  1/15/10	1. A support plan for resident 2 was completed on 1/6/10. Resident 3 expired 1/7/10. 2. The Executive Director conducted an audit 12/31/09 and determined that all remaining residents in building 1 had a support plan on file. 3. Following this audit it was determined that a tickler system needed to be re-established by the Director of Resident Care to track that support plans are completed timely. The tickler system was re-implemented 1/15/10.	4/12/10 



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<p>51, 52</p> <p>51 Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. §§ 10225.101-10225.5102) and 6 Pa.Code Chapter 15 (protective services for older adults).</p> <p>52 Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and 6 Pa.Code Chapter 15 (protective services for older adults) and other applicable regulations.</p>	<p>The home did not complete a criminal history check for the home's hairstylist.</p> <p>The home did not complete a criminal history check for Hospice staff person A, who provides care to Resident #4 and Hospice staff person B, who provides care to Resident #4 and #5.</p>	<p>12/23/09 &amp; 1/20/10</p> <p>12/30/09</p>	<p>1. The criminal history check for the homes hair stylist was obtained 12/23/09. The criminal history check for the two hospice workers was obtained 1/20/10.</p> <p>2. An audit of personnel and consultant records was completed on 12/31/09 and no additional criminal checks were found to be missing.</p>	<p>4/12/10 </p>




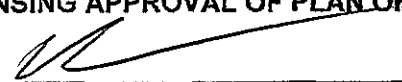
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91 Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control center, municipal emergency management agency and personal care home complaint hotline shall be posted on or by each telephone with an outside line.	The phone in the kitchenette area did not have any of the required emergency phone numbers posted on or near the phone.	12/18/09  1/15/10	1. The required emergency phone numbers were posted in the kitchenette area on 12/18/09. 2. The Executive Director and housekeeper conducted a tour of the residence and determined that the required emergency numbers were posted in all common areas however five private office phones lacked the full listing of the required emergency numbers. The full listing of the required emergency numbers was posted by each of the five phones 1/15/10.	4/5/10 CB




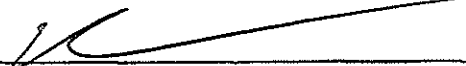
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91 Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control center, municipal emergency management agency and personal care home complaint hotline shall be posted on or by each telephone with an outside line.	The phone in the kitchenette area did not have any of the required emergency phone numbers posted on or near the phone.	2/1/10  2/1/10	3. A checklist was developed to ensure that all phones are checked monthly to ensure the required emergency numbers remain posted 2/1/10 4. The Executive Director and/or designee shall complete the checklist monthly and re-post the emergency numbers as needed.	<i>Cont'd</i>


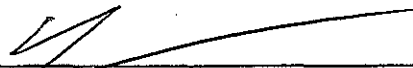
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130h The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.	The home's emergency procedures do not include a procedure to implement in the event the fire alarm and smoke detector systems are inoperable.	12/18/09 <i>(CK 2/10)</i>	1. The emergency / disaster plan was revised to reflect that a 30 minute fire watch would be implemented in the event the fire alarm or smoke detector system would be inoperable. The revision was reviewed with the on site DPW inspector on 12/18/09 and deemed acceptable.  2. The emergency plan was rewritten in November of 2009. The index of the new plan was compared to the previous plan and no other omissions were identified.	4/5/10 



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130h The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.	The home's emergency procedures do not include a procedure to implement in the event the fire alarm and smoke detector systems are inoperable.		3. The Executive Director and Environmental Services Director are aware of the essential elements which must be contained in the emergency plan. The procedure to address failure of the fire alarm or smoke detection system was an omission during the revision process.  4. The Executive Director and Environmental Services Director will review the plan at least annually going forward and adjust the plan as needed.	<p align="center"><u>Cont'd</u></p>



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132h Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.	The home's fire drill record indicates that a drill was conducted on 9/1/09 when 15 residents were in the home; however 14 residents were evacuated. The home did not evacuate one resident who receives Hospice Care.  Staff person E confirmed that the home does not evacuate residents who receive Hospice Care.	4/5/10	1. The home did not evacuate the hospice resident on 9/1/09 due to his frail condition and failing health. 2. The facility reviewed fire drill records and determined that there was an additional occurrence on 12/30/09 that a resident receiving hospice was not evacuated.  <i>The home will follow the DPW statement of Policy with regards to evacuation of residents who are receiving hospice care services. Residents who do not meet the requirements will be evacuated during fire drills. CB 4/5/10</i>	4/13/10 <i>CB</i>


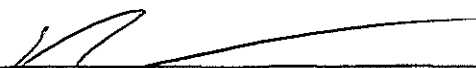



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132h Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.	The home's fire drill record indicates that a drill was conducted on 9/1/09 when 15 residents were in the home; however 14 residents were evacuated. The home did not evacuate one resident who receives Hospice Care.  Staff person E confirmed that the home does not evacuate residents who receive Hospice Care.	12/30/09           1/1/10	3. Staff received education during a mandatory staff meeting on 12/30/09 that residents receiving hospice care are required per regulation to participate in fire safety drills. Going forward, when a resident elects hospice, the residents condition and plan of care will be reviewed for changes which will be reflected in the support plan. 4. The Executive Director and the Environmental Services Director will review all fire drill records monthly to verify that all residents participate. In addition staff will be asked after each fire drill if any difficulty was experienced evacuating any resident. Employee orientation as of January 1, 2010 has been revised to stress to staff that all residents are required to participate in safety drills	<u>Cont'd</u>

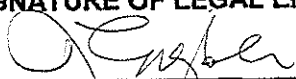
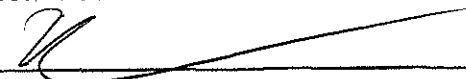
**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

<b>NAME AND ADDRESS OF PERSONAL CARE HOME</b> Magnolias of Chambersburg Building 1 735 Norland Avenue Chambersburg, PA 17201		<b>CURRENT LICENSE NUMBER</b>  307670	
<b>INSPECTION DATE(S) (Include all dates of the inspection)</b> December 18, 2009		<b>REGIONAL REPRESENTATIVE</b> Jaime Erb, Lynn Loudenslager	
<b>SIGNATURE OF LEGAL ENTITY</b> 	<b>DATE</b> 2/8/10	<b>REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION</b> 	<b>DATE</b> 3/17/10

1 REGULATION 55 Pa.Code §.2600.	2 VIOLATION	3 DATE BY WHICH CORRECTION WILL BE COMPLETED	4 PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	5 DATE COMPLIANCE VERIFIED BY DPW
141a The medical evaluation shall include the following:  (5) Allergies. (6) Immunization history. (7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications. (10) Mobility assessment, updated annually or at the Department's request.	Resident #2's medical evaluation, dated 11/6/09, is missing information pertaining to allergies, immunization history, and medication regimen.  Resident #5's medical evaluation, dated 9/23/09, is missing the mobility assessment.	1/31/10           1/25/10	1. The physician's office was contacted to complete the medical information pertinent to diagnosis, treatment in case of an emergency and immunization history for resident 2. The medical evaluation for resident #5 should have reflected the resident was immobile. The resident expired 1/7/10. 2. The Director of Resident Care conducted an audit to determine the timeliness and accuracy of medical evaluations for all in-house residents of building 2. The audit indicates that three annual medical evaluations were not completed timely and six evaluations reflected missing data or needed updated data.	Steps have been take to correct violation; full compliance is not verifiable 4/13/10 Date Initials (DPW) 

**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

A


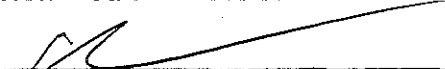
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**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**


B

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**VIOLATION REPORT  
PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

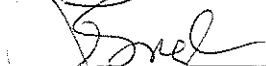

<b>NAME AND ADDRESS OF PERSONAL CARE HOME</b> Magnollas of Chambersburg Building 1 735 Norland Avenue Chambersburg, PA 17201		<b>CURRENT LICENSE NUMBER</b>  307670	
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141b1 A resident shall have a medical evaluation at least annually.	Resident #6, admitted 4/2/07, has a medical evaluation dated 4/1/08; however the annual medical evaluation was completed on 8/24/09.	1/25/10	1. The medical evaluation for resident 6 was not timely when completed on 8/24/09 but is an accurate reflection of the resident's current condition. 2. The Director of Resident Care conducted an audit of residents residing in building one on 1/25/10 and determined that five medical evaluations were completed late but did reflect the resident's current condition.	4/13/10 



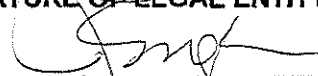

**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

8-1

<b>NAME AND ADDRESS OF PERSONAL CARE HOME</b> Magnollas of Chambersburg Building 1 735 Norland Avenue Chambersburg, PA 17201		<b>CURRENT LICENSE NUMBER</b>  307670	
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<b>SIGNATURE OF LEGAL ENTITY</b> 	<b>DATE</b> 2/8/10	<b>REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION</b> 	<b>DATE</b> 3/17/10

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141b1 A resident shall have a medical evaluation at least annually.	Resident #6, admitted 4/2/07, has a medical evaluation dated 4/1/08; however the annual medical evaluation was completed on 8/24/09.	1/15/10          2/1/10	3. Following a thorough review it was determined that a tickler system needed to be re-established by the Director of Resident Care to track the timeliness of medical evaluations.  4. The Director of Resident Care is now working with an automated tickler system to track timeliness of medical evaluations. The Executive Director will spot check the evaluations are present and the tickler system is maintained.	<u>Cont'd</u>



**VIOLATION REPORT  
PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**


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141b2 A resident shall have a new medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation.	Resident #5, admitted 9/30/09, has a medical evaluation dated 9/23/09. Resident #5 started to receive Hospice services on 10/28/09. A new medical evaluation was not completed to reflect the resident's change in condition.	1/31/10	1. Resident 5 expired 1/7/10. 2. The Director of Resident Care audited the charts of three residents receiving hospice care and confirmed that the medical evaluation reflected this service. 3. Care staff were in-serviced on 1/27/10 to recognize changes in resident condition including provision of hospice care that will trigger a new medical evaluation prior to the annual review date and an update to the support plan.	4/13/10 CB





**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**


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185b At a minimum, the procedures in 185a shall include:  (1) Documentation of the receipt of controlled substances and prescription medications. (2) A process to investigate and account for missing medications and medication errors. (3) Limited access to medication storage areas. (4) Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply for a resident who self-administers his medication without the assistance of a staff person and stores his medication in his/her room.	Resident #2 has a prescription order for Hydrocodone. During a medication audit, the narcotic count sheet for the Hydrocodone indicated that Hydrocodone tablets were removed from the packet on 11/12/09, 11/13/09, 11/26/09, 12/5/09, and 12/14/09; however Resident #2's medication administration record is missing documentation of the administration of the Hydrocodone.	1/31/10	1. One medication assistant responsible for the lack of documentation is no longer employed and the remaining two assistants were disciplined concerning poor practice. 2. The MAR's for the community were checked on 1/31/10 to identify any omissions and to identify any trends. No trends were identified.	



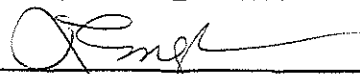

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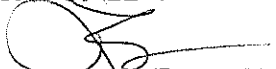
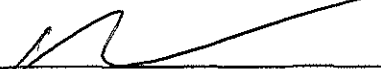
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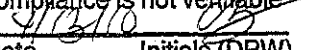
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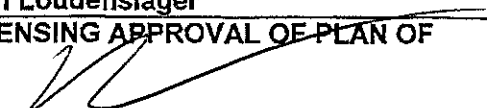
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**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

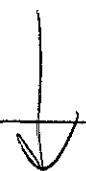
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187a A medication record shall be kept to include the following for each resident for whom medications are administered: nata (PRN).  (14) Name and initials of the staff person administering the medication.	Direct care staff person C and D administered medications to residents on 12/17/09; however direct care staff person C and D did not sign the December 2009 Master Key.  Repeated Violation: 8/11/08	12/22/09  12/24/09  2/24/10  2/24/10	1. Staff persons C and D have signed the Master Signature sheet for December/200 on 12/22/09. 2. The master signature key was re-checked and no other signatures were needed. 3. The Director of Resident Care has revised the signature sheet with pre-printed names and signatures of medication assistants will be obtained at our mandatory staff meeting which is held monthly beginning 2/24/10. 4. The Executive Director will review the master signature sheet at the conclusion of the monthly meeting to verify all signatures of medication assistants are present.	Steps have been take to correct violation; full compliance is not verifiable  Date <u>3/17/10</u> Initials (DPW) <u>OS</u>



**VIOLATION REPORT  
PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**


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224c The preadmission screening shall be completed by the administrator or designee.	Resident #1, admitted 12/8/09, has a preadmission screening, dated 12/9/09, completed by his/her physician.  Resident #2, admitted 11/6/09, has a preadmission screening, dated 11/6/09, completed by a Chambersburg Hospital Social Worker.	1/31/10	1. The pre-admission assessment for resident 1 was completed by her physician one day after the admission of the resident. Although the screening was completed late, it accurately reflects the residents needs. 2. The Executive Director completed an audit of records for residents in building one and determined that all pre-admission assessments were completed timely however, eight of the assessments were completed by health professionals other than community staff.	Steps have been take to correct violation; full compliance is not verifiable Date <u>2/13/10</u> Initials (DPW) <u>JS</u>





**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

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224c The preadmission screening shall be completed by the administrator or designee.	Resident #1, admitted 12/8/09, has a preadmission screening, dated 12/9/09, completed by his/her physician.  Resident #2, admitted 11/6/09, has a preadmission screening, dated 11/6/09, completed by a Chambersburg Hospital Social Worker.	1/15/10	3. Staff responsible for completing the pre-admission screening have been in-serviced on this requirement and will complete the assessments timely going forward.  	<u>Cont'd</u>



**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

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**VIOLATION REPORT**  
**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**

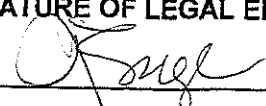

<b>NAME AND ADDRESS OF PERSONAL CARE HOME</b> Magnolias of Chambersburg Building 1 735 Norland Avenue Chambersburg, PA 17201		<b>CURRENT LICENSE NUMBER</b>  307670	
<b>INSPECTION DATE(S) (Include all dates of the inspection)</b> December 18, 2009		<b>REGIONAL REPRESENTATIVE</b> Jaime Erb, Lynn Loudenslager	
<b>SIGNATURE OF LEGAL ENTITY</b> 	<b>DATE</b> 2/8/10	<b>REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION</b> 	<b>DATE</b> 3/17/10

1 REGULATION 55 Pa.Code § 2600.	2 VIOLATION	3 DATE BY WHICH CORRECTION WILL BE COMPLETED	4 PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	5 DATE COMPLIANCE VERIFIED BY DPW
225c The resident shall have additional assessments as follows:  (1) Annually. (2) If the condition of the resident significantly changes prior to the annual assessment.	Resident #6, admitted 4/2/07, has an assessment dated 3/24/08; however the annual assessment was not completed until 5/11/09.  Resident #5, admitted 9/30/09, started to receive Hospice on 10/28/09. A new assessment was not completed to reflect this change in condition.	2/1/10	4. Staff were educated at our monthly training session on 1/27/10 to better understand resident changes in functional status including implementation of hospice services that may trigger need for further assessment prior to the annual review date.	Cont'd




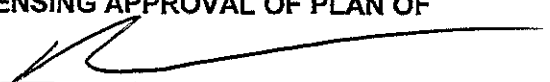
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**PERSONAL CARE HOMES – 55 Pa.Code Chapter 2600**


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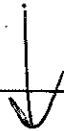
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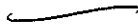
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226a The resident shall be assessed for mobility needs as part of the resident's assessment.	The 11/23/09 assessment for Resident #7 indicates that the resident is mobile however the medical evaluation for Resident #7, dated 11/23/09, indicates that the resident is immobile. The physician was not contacted regarding the discrepancy.	1/31/10  2/1/10	1. The physician was contacted concerning the mobility status of resident 7 and the discrepancy was resolved. 2. The mobility status of all residents in building 1 was reviewed and as this is a secured unit for dementia care all residents are considered immobile as all would have difficulty in understanding and carrying out instructions in the event of an emergency. Four residents required updating on their mobility status.	 4/13/10



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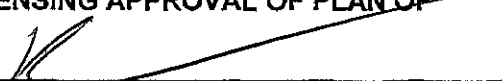
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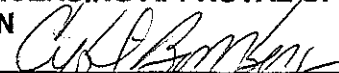
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226a The resident shall be assessed for mobility needs as part of the resident's assessment.	The 11/23/09 assessment for Resident #7 indicates that the resident is mobile however the medical evaluation for Resident #7, dated 11/23/09, indicates that the resident is immobile. The physician was not contacted regarding the discrepancy.	2/1/10	4. The Director of Resident Care will review each medical evaluation to verify that the assessment and the physician's evaluation concur. In the event of a discrepancy, the Director of Resident Care or designee shall contact the physician for resolution. The Executive Director will audit three charts per month to ensure the assessment and medical evaluation are in agreement and reflect an accurate profile of the residents needs.	Cont'd






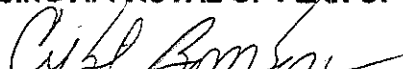
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233a Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.	The home did not have written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the locking system currently in use at the home.  Repeated Violation: 8/11/08	<del>7/25/10</del>  1/25/10  4/30/10	1. An approval letter from DPW dated <del>10/4/04</del> was obtained from the corporate office to satisfy this requirement. <i>NOT ACCEPTABLE</i> 2. The Executive Director reviewed administrative files for the community and did not identify any further special approval letters granted to the community.  - per phone call to the Administrator, the Home is in the process of obtaining a copy of the written approval from L+I that permits the locking system that is in use in the home.	4/13/10 

CS 4/13/10.

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233b A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:  (1) Upon a signal from an activated fire alarm system, heat or smoke detector. (2) Power failure to the home. (3) Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.	The home does not have a statement from the manufacturer verifying that the magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs: a signal from an activated fire alarm system, heat or smoke detector, power failure to the home and overriding the magnetic locking system by use of a key pad or other lock-releasing device.  Repeated Violation: 8/11/08	1/25/10   1/25/10   4/30/10	1. The attached literature provided by the manufacturer confirms that the locking system in place meets both life safety and security needs as well as all requirements of NFPA101.  2. The Executive Director reviewed administrative files for the community and did not identify any further manufacturer's statements on file related to the security system.  The administrator is working to obtain documentation that the locking system in place in the	Steps have been take to correct violation; full compliance is not verifiable 4/13/10 Date Initials (DPW)

*home will shut down and the doors will release + open easily when the fire alarms are activated, there is a power failure in the keypad is used to override the system. as 4/5/10*