pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: June 28, 2018

Ms. Loriann Putzier,
President & COO
Tithonus Chambersburg LP
C/O Integracare Corporation
6600 Brooktree Court, Suite 1000
Wexford, Pennsylvania 15090

RE: Magnolias of Chambersburg- Building 1
735 Norland Avenue
Chambersburg, Pennsylvania 17201
Certificate #: 307670

Dear Ms. Putzier:

As a result of the Department's Bureau of Human Services Licensing inspection on March 20, 2018, March 30, 2018 and June 6, 2018 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: MAGNOLIAS OF CHAMBERSBURG BUILDING 1	**License Number:** 30767
Address: 735 NORLAND AVENUE, CHAMBERSBURG, PA 17201	**County:** Franklin
Administrator: Tressia Day	**Region:** CENTRAL
Legal Entity Name: TITHONUS CHAMBERSBURG LP	
Legal Entity Address: 6600 BROOKTREE COURT SUITE 1000, WEXFORD, PA 15090	

Certificate(s) of Occupancy

C-2 LP
03/20/1998
Labor & Industry

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 42 **Waking Staff:** 32

Type of Inspection: Partial **BHA Docket Number:** **Notice:** Unannounced

Reason(s) for Inspection(s)

Incident

On-Site Inspections Dates and Department Representatives On-Site

03/20/2018: McCloskey, Jason; Heemer, Laura
03/30/2018: McCloskey, Jason; Heemer, Laura

Off-Site Inspection Dates and Inspectors, if Applicable

03/26/2018: McCloskey, Jason

Other Details

Partial or Full Triggers: **Random Indicators:**

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 26

Number of Residents Served: 21

Secured Dementia Care Unit in Home: Yes

Area: Entire Home

Secured Dementia Unit Capacity, if Applicable: 26

Number of Residents Served in Secured Dementia Care Unit, if applicable: 21

Number of Current Hospice Residents: 5

Number of Hospice Residents in past year: 3

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 21

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 21

Have a Physical Disability: 0

Violation Report: 30767 - 03/20/2018 - McCloskey, Jason
PCH Name: MAGNOLIAS OF CHAMBERSBURG BUILDING 1

1. REGULATION 55 Pa.Code §2600

2600.15(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 - 10225.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

2a. DESCRIPTION OF VIOLATION

On 3/8/18, an act of alleged abuse against resident Resident #1 was reported to the home. The home did not submit a complete, written mandatory abuse report to the local Area Agency on Aging until 14 days after the abuse occurred. The written report is required to be sent to the Area Agency on Aging within 48 hours.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Attachment #1 Pages 2A and 2B
(18 pages)

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Directo Date 5-3-18

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/8/18 (Date)

The above plan of correction was approved by BDS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg

License Number: 307670

Date of Visit: March 20th and 30th 2018

Date of Submission: 5-3-18

1. Violation Review: On 3/8/18, an act of alleged abuse against Resident #1 was reported to the home. The home did not submit a complete, written mandatory abuse report to the local Area Agency on Aging until 14 days after the abuse occurred. The written report to be sent to the Area Agency on Aging within 48 hours.

2. Violation Interpretative Statement: 2600.15(a)- The home shall immediately report suspected abuse of a residents served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Section 10225.701-10225.707) and 6 Pa. Code Sections 15.21-15.27 (related to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

3. Review the benefit of the Regulation, per RCG: Ensures that abuse or suspected abuse is appropriately reported and investigated.

4. Description of the Repair of the Immediate Problem: On 3/20/18 when DHS was at the community it was discovered by them that the Mandatory Report was not completed fully by DCS as well as not reported to AAA within the 48 hr timeframe. When receiving a return call from AAA on 3/22/18 to verify if they received report DRCS spoke with [redacted] (AAA) who stated they did not have report on file, DRCS located completed form and immediately sent the Mandatory Abuse form for resident #1 via fax on 3/22/18 (Attached receipt of fax)

5. Determine / document the Root Cause of the Violation: DCS/ DRCS failed to follow procedure to fax mandatory abuse report to AAA within 48 hours of incident until it was discovered on 3/20/18 by DHS. DRCS/ED failed to follow up with the mandatory abuse report in a timely manner to insure the incident/abuse procedure were completed correctly and faxed to AAA in the appropriate time frame by any staff person.

6. Detail Action Steps / System Developed to prevent future occurrence:
    a. Changing practice? Effective 5/4/18 a daily review of all incidents will be completed at our morning mangers meeting by DRCS/ED and/or Manger on Duty (MOD) during the weekends to determine if any incident meet the criteria for abuse reporting therefore, followed by completing a mandatory abuse report and faxing within 48 hrs by the

Authorized Signature Jessica Day Date: 5-3-18

ED/DRCS or MOD in the event of any reports of abuse and documented on morning stand up form and MOD form. (attached)

b. Teaching or Training? On 4/19/18, DRCS review of the COSM policy was conduct to include the review of the mandatory abuse form with all staff members accordingly. (Find attached the training agenda and sign in sheet)

c. On-going Monitoring? DRCS and/or ED will monitor all incidents with abuse allegations to ensure reports have been sent to AAA, ED will be required to initial, time, and date fax receipt to verify it has been sent in the appropriate 48 hour window.

7. Designated position responsible and specify target date for correction. Resident care staff, Director of Resident Care (DRCS), Executive Director (ED)
Staff training completed on 4/19/18
Report faxed to AAA on 3/22/18
New review during stand up with managers effective 5/3/18

Authorized Signature Tammie Day Date: 5-3-18

Violation Report: 30767 - 03/20/2018 - McCloskey, Jason
PCH Name: MAGNOLIAS OF CHAMBERSBURG BUILDING 1

1. REGULATION 55 Pa.Code §2600
2600.60(a) - Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION
The home's general pattern of staffing includes 2 direct care staff per shift and, when staffing is available, 2 half-shift staff people between the hours of 7:00am through 11:00am, and 4:00pm through 8:00pm. The home currently has 21 residents with mobility needs. In addition to direct care duties, staff are required to perform ancillary functions like serving meals, clearing tables, emptying trash, and washing and returning laundry.

The staffing provided by the home is not adequate to meet the needs of the residents as evidenced by the following:
- Multiple instances of physical altercations between residents including two incidents occuring within 15 minutes of one another on 3/3/18 when Resident #3 was hit in the chest by Resident #4; an incident on 3/8/18 when Resident #2 was observed grabbing the neck of Resident #1; and an incident on 3/14/18 when Resident #5's arm was being held by Resident #6 resulting in Resident #6 striking Resident #5 several times.
- At approximately 10:28am on 3/30/18, for a period of approximately 10 minutes, a licensing representative attempted to locate staff to provide assistance to Resident #4. Although two hospice staff were present in the home's dining area, they did not know where the home's staff were or how to reach them. When staff was located, one stated that he/she was helping to bathe a resident while the other staff person stated he/she was assisting a resident with being changed and emptying trash. When Staff Person A returned at approximately 10:46am, he/she stated that the staff was probably all busy providing AM care because "it's the busy time."
- On 3/30/18 at approximately 12:10pm, representatives observed Resident #8 left in a reclined Broda Chair in front of a TV in the lounge area. The TV was repeatedly playing the introductory screen of the movie "Roman Holiday" until 12:23pm when another staff person brought Resident #9 into the room, in a reclined Broda Chair, and hit the play button on the DVD. A visitor to the home explained to licensing representatives that "the same movie plays all the time" and that the chairs are used to prevent the residents from getting up and walking.
- On 3/30/18 at approximately 2:15pm, while interviewing a resident's family member, a loud commotion was heard in the hallway as Resident #7 was yelling and tugging violently on the door to the courtyard. The behavior subsided then moments later erupted again. The licensing representative attempted to locate staff to redirect the resident,but was unable to locate anyone. The licensing representative activated a door alarm alarm to elicit staff assistance. Staff Person A responded in a moment and explained that the reason someone didn't come sooner was because all of the staff were in a change-of-shift meeting.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Pages 3A, 3B, and 3C

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Director **Date** 5-3-18

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The above plan of correction is approved as of 5/8/18 (Date)

The above plan of correction was approved by BJS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg

License Number: 307670

Date of Visit: March 20th and 30th 2018

Date of Submission: 5/3/18

1. Violation Review: The home's general pattern of staffing includes 2 direct care staff per shift and, when staffing is available, 2 half-staff people between the hours of 7:00am through 11:00am, and 4:00pm through 8:00pm. The home currently had 21 residents with mobility needs. In addition to direct care duties, staff are required to perform ancillary functions like serving meals, clearing tables, emptying trash, and washing and returning laundry.

   The staffing provided by the home is not adequate to meet the needs of the residents as evidenced by the following:
   -Multiple instances of physical altercations between residents including two incidents occurring within 15 minutes of one another on 3/3/18 when Resident # 3 was hit in the chest by Resident #4l an incident on 3/8/18 when Resident #2 was observed grabbing the neck of Resident #1; and an incident on 3/14/18 when Resident #5's arm was being held by Resident #6 resulting in Resident #6 striking Residents #4 several times.
   -At approximately 10:28am on 3/30/18, for a period of approximately 10 minutes, a licensing representative attempted to locate staff to provide assistance to Resident #4. Although two hospice staff was present in the home's dining area, they did not know where the home's staff was or how to reach them. When staff was located, one stated that he/she was helping to bathe a resident while the other staff person stated he/she was assisting a resident with being changed and emptying trash. When Staff person A returned at approximately 10:46am, he/she stated that the staff was provably all busy providing AM care because "it's the busy time."
   -On 3/30/18 at approximately 12:10pm, representatives observed Resident #8 left in a reclined Broda Chair in front of a TV in the lounge area. The TV was repeatedly playing the introductory screen of the movie "Roman Holiday" until 12:23pm when another staff person brought Resident #9 into the room in a reclined Broda Chair, and hit the play button on the DVD. A visitor to the home explained to licensing representative the "the same movie plays all the time" and that the chairs are used to prevent the resident from getting up and walking.
   -On 3/30/18 at approximately 2:15pm, while interviewing a resident family member a loud commotion was heard in the hallway as Resident #7 was yelling and tugging violently on the door to the courtyard. The behavior subsided then moments later erupted again. The licensing representative attempted to locate staff to redirect the resident, but was unable to locate anyone. The licensing's representative activated a door alarm to elicit staff assistance. Staff

Authorized Signature Jennie Day Date: 5-3-18

Person A responded in a moment and explained that the reason someone didn't come sooner was because all of the staff were in a change of shift meeting.

2. Violation Interpretative Statement: 2600.60(a)-Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

3. Review the benefit of the Regulation, per RCG: Ensures that there are sufficient staff persons on duty at all times to meet residents' needs.

4. Description of the Repair of the Immediate Problem: Effective immediately, the home will staff the program consistent with the occupancy and needs of the Residents. The pattern established for the current occupancy and acuity far exceeds the state minimum staffing guidelines. Staff and managers qualified to deliver personal care will be scheduled accordingly to meet the staffing hours necessary, effective 5/7/18.

5. Determine / document the Root Cause of the Violation: The home's established staffing pattern allows for sufficient staff hours for the care needs of the Residents within the program, however:
    a. Recruitment and retention challenges have compromised our ability to maintain our own desired staffing pattern and the short fall in hours worked was not planned for;
    b. The routines of care and daily life established for the program were not evidenced by the DCS team during the period of observation by the surveyor. Additional supervision is necessary from Management. This DCS team will develop a flow of work necessary for the Daily Routines, and system of accountability that meets the needs of our Resident population.

6. Detail Action Steps / System Developed to prevent future occurrence:
    a. ED and DRCS will continue the recruitment, screening, hiring, on-boarding, training and engagement process to secure the appropriate number of Direct Care Staff for the memory care program.
    b. In the interim, the Management will ensure that the established staffing pattern is adhered to through the use of personnel trained and qualified to perform DCS duties.
    c. The Executive Director, the Director of Resident Care and the Life Stories Director will develop, implement and monitor a Daily Routine Work flow plan that is reflective of staff functions and responsibilities to support routines of care, supervision and Resident daily life to meet Residents' needs individually and in aggregate. The plan will be reflective of shift, time-blocks and positions highlighting key functions and accountabilities. This plan will consider timing and contribution of ancillary staff to support when most appropriate. Medication administration and meal times and routines will be examined to maximize the availability of staff to meet Resident needs. The plan will be implemented and monitored daily on all shifts to establish new routines and compliance with standards of care.

Authorized Signature [signature] Date: 5-3-18

d. The Life*Stories* Director will develop a series of appropriate normalized and sensory activities that reflect the interests, preferences and abilities of the Resident population, and teach the DCS team to engage with the Resident, during times consistent with the Daily Routine and Work flow plan. Additionally, audio equipment and supplies will be verified to be in good working order, of sufficient variety, and enjoyable to the Residents, and will be monitored for such, on-going. Staff will be trained on how to operate equipment in the absence of management.

7. Designated position responsible and specify target date for correction.
   a. The ED will manage the recruitment and retention process. Documentation of job postings, interview results and on-boarding activities will be maintained. Progress to be measured monthly by review of open positions and effort to fill them. Immediately and on-going. Documentation to be maintained.
   b. The ED will ensure the memory care program is staffed according to the established parameters, effective May 7, 2018. Documentation to be maintained.
   c. The Daily Routines and Work-flow plan will be developed by the Executive Director, the Director of Resident Care and the Life*Stories* Director by May 11, 2018 Documentation and progress to be maintained for review by DHS.
   d. The Director of Life*Stories* will review available activity sources and supplies for appropriate opportunity and means for staff to engage more directly with Residents. Items will be available and reviewed with DCS by 5/11/18. Documentation of available resources and supplies will be maintained, and training outline/s and sign-in sheet/s will be maintained. Resident attendance and participation logs will be maintained.

Authorized Signature Teresa Day Date: 5-3-18

Violation Report: 30767 - 03/20/2018 - McCloskey, Jason
PCH Name: MAGNOLIAS OF CHAMBERSBURG BUILDING 1

1. REGULATION 55 Pa.Code §2600

2600.82(c) - Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

2a. DESCRIPTION OF VIOLATION

On 3/20/18, approximately (30) 1.5 ounce bottles of McKesson anti-perspirant deodorant with a warning label stating, "If swallowed, get medical help or contact a poison control center immediately" were accessible to residents inside an unlocked closet at the front of the home. On 3/30/18, the same closet was unlocked and contained approximately (50) 1.5 ounce bottles of McKesson anti-perspirant deodorant.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See page 4A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Director **Date** 5-3-18

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/8/18 (Date)

The above plan of correction was approved by BDS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg

License Number: 307670

Date of Visit: March 20th and 30th 2018

Date of Submission: 5/3/18

1. Violation Review: On 3/20/18m approximately (30) 1.5 ounce bottles of McKesson anti-perspirant deodorant with a warning label stating, "if swallowed, get medical help or contact a poison control center immediately"

2. Violation Interpretative Statement: 2600.82 (c)- Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

3. Review the benefit of the Regulation, per RCG: Protects resident who are unable to safely use or avoid poisonous materials from illness, injury, or death related to misuse of accessible poisons.

4. Description of the Repair of the Immediate Problem: The closet was checked frequently by Management to ensure it was locked until 4/4/18 when a new lock was installed that locks automatically with closure and stationary side was permanently locked to prevent closet from being open at any time unless unlocked by a key.

5. Determine / document the Root Cause of the Violation: DCS failed to follow regulations of securing poison substances by leaving closet unlocked after entering , management team did not have in place a procedure to ensure closets remained locked at all times. The lock was not a lock that could automatically lock with closure.

6. Detail Action Steps / System Developed to prevent future occurrence:
    a. Teaching or Training? On 4/19/18 during a community staff training/meeting DCS was notified of new lock and procedures for why lock was changed. Regulation 2600.82 (c) was reviewed during this meeting. (Find attached is staff sign in sheet and meeting notes).
    b. On-going Monitoring? Management will check during community rounds for compliance.

7. Designated position responsible and specify target date for correction. Environmental Services (ES), All care staff

Authorized Signature Tamara Day Date: 5-3-18

Violation Report: 30767 - 03/20/2018 - McCloskey, Jason
PCH Name: MAGNOLIAS OF CHAMBERSBURG BUILDING 1

1. REGULATION 55 Pa.Code §2600

2600.202 - The following procedures are prohibited:

(1) Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited.

(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.

(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited.

(5) A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited.

(6) A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited.

2a. DESCRIPTION OF VIOLATION

On 3/20 and 3/30/18, licensing representatives observed multiple residents in reclined Broda Chairs including Resident #s 8, 9, 10, 11 and 12. According to a contracted health aide working in the home, residents are routinely left in reclined Broda Chairs to prevent them from getting up and falling; chairs are reclined more when the residents are left alone and reclined less when the residents are up against a table or other barrier to prevent them from getting up. During the inspection dates, licensing representatives observed residents left for hours in their chairs, including on 3/30/18 at approximately 12:10pm, representatives observed Resident #8 left in a reclined Broda Chair in front of a TV in the lounge area. The TV was repeatedly playing the introductory screen of the movie "Roman Holiday" until 12:23pm when another staff person brought Resident #9 into the room, in a reclined Broda Chair, and hit the play button on the DVD. At approximately 4:10pm, Resident #8 was observed attempting to stand and nearly fell while trying to climb over the armrest of the Broda chair. The use of geriatric chairs is prohibited unless the device is used to provide support for body positioning and has been prescribed by a medical professional.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Pages 5A, 5B, and 5C

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Director — **Date** 5-3-18

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The above plan of correction was approved by BKS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully implemented
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PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg

License Number: 307670

Date of Visit: March 20th and 30th 2018

Date of Submission: 5/3/18

1. Violation Review: On 3/20 and 3/30/18, licensing representatives observed multiple residents in reclined Broda Chairs including Residents # 8, 9, 10, 11, and 12. According to a contracted health aide working in the home, residents are routinely left in reclined Broda chairs to prevent them from getting up and falling; chairs are reclined more when the residents are left alone and reclined less when the residents are up against a table or other barrier to prevent them for getting up. During the inspection dates, licensing representatives observed residents left for hours in their chairs, including on 3/30/18 at approximately 12:10 pm, representative observed Resident #8 left in a reclined Broda Chair in front of a TV in the lounge area. The TB was repeatedly playing the introductory screen of the movie "Roman Holiday" until 12:23 pm when another staff person brought Resident #9 into the room, in a reclined Broda Chair, and hit the play button on the DVD. At approximately 4:10 pm, Resident #8 was observed attempting to stand and nearly fell while trying to climb over the armrest of the Broda Chair. The use of geriatric chairs is prohibited unless the device is used to provide support for the body positioning and has been prescribed by a medical professional.

2. Violation Interpretative Statement: 2600.202- The following procedures are prohibited:
   (1) Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited.
   (2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
   (3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, are prohibited.
   (4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited.
   (5) A mechanical restraint, defined as a device that restricts the movement of function of a resident or portion of a resident's body, is prohibited.
   (6) A manual restraint, defined as a hands-on-physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited.

3. Review the benefit of the Regulation, per RCG: Protects residents' rights to be free from restraints with dignity and respect, and be served in the least-restrictive setting possible.

Authorized Signature Tracie Day Date: 5-3-18

4. Description of the Repair of the Immediate Problem:
   a. Description of the Repair of the Immediate Problem: Original physician orders for the Broda chair equipment were submitted to DHS.
   b. An inter-disciplinary team consisting of the home's Executive Director, the Director of Resident Care Services, Hospice Team Leader, Therapy provider if hospice cannot provide IntegraCare Regional Team members, Medical Director and family will individually assess, determine and document each Resident's ability to safely use alternate durable medical equipment for the purpose of ambulation and engaging in community life. Where possible, less restrictive alternatives and interventions will be selected, ordered and provided as soon as possible. Where such alternative equipment further compromises the safety needs of the Resident, alternative placement options will be documented and provided to family, excepting instances where death of the Resident is imminent. Resident Assessment and Support Plans will be updated to reflect care decisions.

5. Determine / document the Root Cause of the Violation:
   The Broda chair equipment was provided by hospice in consideration for the significant decline in each Resident's functional abilities and need for safe method to remain engaged in community life. This equipment is widely accepted to support aging-in-place, and in each case was ordered by qualified physician as positioning devices necessary to protect the resident from harm, ensure proper positioning and decrease the risk of pressure injury. Each Resident identified suffers from gait Apraxia, which is the inability to coordinate purposeful movement due to the advancement of the Resident's cognitive impairment or disease process associated with the brain. Due in part to the relative safety provided by the equipment, an over-reliance on the equipment has developed.

6. Detail Action Steps / System Developed to prevent future occurrence:
   a. The Executive Director will formally convey to hospice and family the intent to seek appropriate alternatives to the Broda chairs through a process of Assessment and consideration of alternate equipment and interventions, educating them on the restrictive implications of the Broda chair equipment. Documentation will be kept.
   b. Current Residents will be evaluated as to their ambulation and positioning needs. Alternative equipment, devices and intervention will be considered and applied as appropriate for each individual, as soon as possible. Documentation will be kept.
   c. Future Residents will be evaluated as to their ambulation and positioning needs, and alternatives to Broda chairs will be generated.
      - Residents who slide as a result of poor positioning, poor trunk strength will be evaluated as to their ability to safely utilize lower height wheelchairs without footrests or footrests in the closed position that allow their feet to touch the floor.

Authorized Signature [signature] Date: 5-3-18

- Evaluate all chairs for correct height, depth and level of backing for each resident individually to have comfortable and safe seating.
- Identify fatigued residents and assign staff to help them to bed to rest.
- Evaluate and individualize the time a resident spends in any chair.
- Employ the use of positioning devices such as body and seat cushions, and padded furniture to off-load weight distribution.
- Consider additional companion services where behaviors associated with gait apraxia might be effectively met

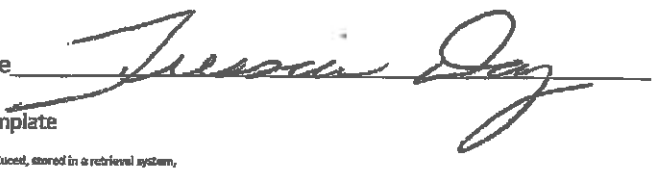
i. Educate staff that social interaction/engagement with and among Residents is their responsibility as well as the Activity Team.

ii. Daily Routine Work flow plan to include considerations:

- Create hour by hour daily schedule for residents (reflected by the Daily Routine work flow plan)
- Identify and offer activities that accommodate the resident's level of functioning that will promote participation.
- Identify and offer many opportunities each day for providing a context with personal meaning.
- Design resident interactions to do *with*, not *for* the residents.
- Utilize resident LifeStory to ensure person-centered care.
- Individualize social activities.
- Reinforce and specifically schedule "Informal/Normalized Activities" everyday interaction: talking with resident, holding their hand, walking with them in the hall or outside areas, taking additional time with ADL needs such as grooming.

d. All staff will receive training and education to staff regarding restraint free care. Training will be documented and maintained.

7. Designated position responsible and specify target date for correction.
The Executive Director will lead the interdisciplinary team to evaluate alternatives to the Broda chairs by 5/11/18
The Executive Director and Director of Resident Care Services and Director of Life*Stories* will develop and implement the Daily Routine and work flow plan by 5/11/18
The Director of Life*Stories* will develop and implement training and a plan to identify and offer activities that accommodate each Residents level of functioning that will promote participation by 5/11/18.
The plan will be implemented and monitored every shift daily for 30-days to evaluate progress and make corrections, and establish new habits for the direct care staff.

Authorized Signature  Date: 5-3-18

Violation Report: 30767 - 03/20/2018 - McCloskey, Jason
PCH Name: MAGNOLIAS OF CHAMBERSBURG BUILDING 1

1. REGULATION 55 Pa.Code §2600

2600.234(d) - The support plan shall be revised at least annually and as the resident's condition changes.

2a. DESCRIPTION OF VIOLATION

Resident #1's most recent resident assessment and support plan (RASP), dated 2/19/18, does not address the resident's need for supervision while eating due to behaviors of yelling and swearing.

Resident #2's most recent RASP, dated 3/12/18, states that the resident has "No problem" with irritability even though the resident "has had several episodes where the resident has been irritable with staff members and other residents." In addition, this RASP indicates that agitation is "No problem." Resident #2, however, has documented physical behavioral issues including an incident on 3/8/18 when s/he grabbed another resident by the neck.

Resident #8's most recent RASP, dated 3/29/18, states that the resident is independent and safely ambulates without assistance. This resident was observed to be unstable when attempting to stand from a Broda Chair and requiring staff assistance .

Resident #9's most recent RASP, dated 5/1/17, does not document a need for assistance when transferring from a bed or chair. The resident uses a Broda Chair and cannot transfer independently.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Attachment #2 Pages 6A and 6B
(43 pages)

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Director **Date** 5-3-18

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/8/18 (Date)

The above plan of correction was approved by BAS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg

License Number: 307670

Date of Visit: March 20th and 30th 2018

Date of Submission: 5/3/18

1. Violation Review: Resident #1's most recent resident assessment and support plan (RASP), dated 2/19/18, does not address the resident's need for supervision while eating due to behaviors of yelling and swearing.
   Resident #2's most recent RASP, dated 3/12/18, states that the resident has "No problem" with irritability even though the resident "had had several episodes where the resident has been irritable with staff members and other residents." In addition, this RASP indicates that agitation is "No problem." Resident #2, however, had documented physical behavioral issues including an incident on 3/8/18 when she grabbed another resident by the neck.
   Resident #8's most recent RASP, dated 3/29/18 states that the resident is independent and safely ambulates without assistance. This resident was observed to be unstable when attempting to stand from a Broda Chair and requiring staff assistance.
   Resident #9's most recent RASP, dated 5/1/17, does not document a need for assistance when transferring form a bed or chair. The resident uses a Broda Chair and cannot transfer independently.

2. Violation Interpretative Statement: 2600.234 (d)- The support plan shall be revised at least annually and as the resident's conditions changes.

3. Review the benefit of the Regulation, per RCG: A person with dementia has rapidly changing mental health and physical health needs; a current assessment-support plan can help to specify how the home will meet the needs of the resident identified in the assessment. It is critical that the home immediately revise the support plan after a significant change to address life safely issues and/or changing needs.

4. Description of the Repair of the Immediate Problem: DRCS reviewed completed a review of all RASP updating those mentioned in this report as well as other resident with behavioral and or ambulatory issues to make sure all RASP were correct. Families were contacted with the updates for appointment to sign updated RASP. (Updated RASP's listed above are attached)

5. Determine / document the Root Cause of the Violation: When changes to residents condition (behaviors/ambulation) DRCS/ED failed to update the RASP in all areas of the RASP pertaining to ambulation and/or transfer or behaviors changes.

Authorized Signature Jessica Day Date: 5-3-18

6. Detail Action Steps / System Developed to prevent future occurrence:
    a. On-going Monitoring? ED and DRCS will continue to monitor RASP for compliance to ensure all information is captured in the appropriate areas of the RASPs for behaviors and ambulation. RASP's are reviewed quarterly by DRCS.

7. Designated position responsible and specify target date for correction. Director of Resident Care Services (DRCS) and Executive Director (ED)

Authorized Signature [signature] Date: 5-3-18

Violation Report: 30767 - 03/20/2018 - McCloskey, Jason
PCH Name: MAGNOLIAS OF CHAMBERSBURG BUILDING 1

1. REGULATION 55 Pa.Code §2600

2600.254(c) - Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

2a. DESCRIPTION OF VIOLATION

On 3/20/18, a green binder labeled "current hospice residents" was stored in the unlocked supply closet at the front of the home and was accessible to residents and visitors. The binder contained the names of twelve residents, including Resident #8, that received hospice services, the dates when services began, and, if applicable, the date of the resident's death.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See pages 7A and 7B

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Director **Date** 5-3-18

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/8/18 (Date)

The above plan of correction was approved by BAS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg

License Number: 307670

Date of Visit: March 20th and 30th 2018

Date of Submission: 5/3/18

1. Violation Review: On 3/20/18, a green binder labeled "current hospice residents" was stored in the unlocked supply closet at the front of the home and was accessible to residents and visitors. The binder contained the names of twelve resident, including Resident #8, that reviewed hospice services, dates when services began, and if applicable, the date of the residents death.

2. Violation Interpretative Statement: 2600.254 (c)- Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administer or the administrators designee, and upon request, to the Department or representatives of Area agency on Aging.

3. Review the benefit of the Regulation, per RCG: Storing resident records in a secure manner while also providing the resident records to individual with authorized access helps to protect the security and privacy of a resident's health information, as well as provide necessary information to those persons who oversee the care of a resident.

4. Description of the Repair of the Immediate Problem: The closet that housed list for supplies provided by Hospice was checked frequently by Management until 4/4/18 to ensure it was locked, on 4/4/18 a new lock was installed that locks automatically with closure and stationary side was permanently locked to prevent closet from being open at any time.

5. Determine / document the Root Cause of the Violation: DCS failed to follow regulations of securing residents records by leaving closet unlocked after entering , management team did not have in place a procedure to ensure closets remained locked at all times.

6. Detail Action Steps / System Developed to prevent future occurrence:
   a. Changing practice? Management will frequently check all closets on daily rounds in the building to ensure closet remains and is locked at all times.
   b. Teaching or Training? On 4/19/18 during a community staff training/meeting DCS was notified of new lock and procedures for why lock was changed. Regulation 2600.82 (c) was reviewed during this meeting.
   c. On-going Monitoring? Management will check during community rounds for compliance.

Authorized Signature Susan Day Date: 5-3-18

7. Designated position responsible and specify target date for correction. Environmental Services (ES), All care staff

Authorized Signature Tressa Day Date: 5-3-18

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: MAGNOLIAS OF CHAMBERSBURG BLDG 1	**License Number:** 30767
Address: 735 NORLAND ROAD, CHAMBERSBURG, PA 17201	**County:** Franklin
Administrator: Tressia Day	**Region:** CENTRAL
Legal Entity Name: TITHONUS CHAMBERSBURG LP	
Legal Entity Address: 6600 BROOKTREE COURT SUITE 1000, WEXFORD, PA 15090	

Certificate(s) of Occupancy

C-2 LP
03/20/1998
L&I

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 40 **Waking Staff:** 30

Type of Inspection: Interim - POC **BHA Docket Number:** **Notice:** Unannounced

Reason(s) for Inspection(s)

Interim

On-Site Inspections Dates and Department Representatives On-Site

06/06/2018: Hoover, Douglas; McCloskey, Jason

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers: **Random Indicators:**

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 26

Number of Residents Served: 20

Secured Dementia Care Unit in Home: Yes

Area: Building 1

Secured Dementia Unit Capacity, if Applicable: 26

Number of Residents Served in Secured Dementia Care Unit, if applicable: 20

Number of Current Hospice Residents: 4

Number of Hospice Residents in past year: 3

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 20

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 20

Have a Physical Disability: 0

Violation Report: 30767 - 06/06/2018 - Hoover, Douglas
PCH Name: MAGNOLIAS OF CHAMBERSBURG BLDG 1

1. REGULATION 55 Pa.Code §2600

2600.82(c) - Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

2a. DESCRIPTION OF VIOLATION

On 6/6/18, the door to the home's kitchen was unlocked allowing access to residents. A container of "Envirox H2 Orange 2 Concentrate Sanitizer" wih the label: "If swallowed, call a poison control center or doctor immediately for treatment advice." was located in cabinet underneath the kitchen sink. The cabinet was unlocked and the poisonous material was accessible to residents who cannot recognize and use poisons safely, including Resident #1, Resident #2, and Resident #3.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See attached. Pages 2A and 2B

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Director

Date 6-20-18

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 6/28/18 (Date)

The above plan of correction was approved by BAS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully implemented
- ☒ Partially implemented - Adequate Progress
- ☐ Partially implemented - Inadequate Progress
- ☐ Not implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg
License Number: 307670
Date of Visit: June 6, 2018
Date of Submission: June 20, 2018

1. Violation Review: On 6/6/18, the door to the home's kitchen was unlocked allowing access to residents. A container of "Envirox H2 Orange 2 Concentrate Sanitizer" with the label: "If swallowed, call poison control center or doctor immediately for treatment advice": was located in cabinet underneath the kitchen sink. The cabinet was unlocked, and the poisonous material was accessible to residents who cannot recognize and use poisons safely, including Resident #1, Resident #2, and Resident #3.

2. Violation Interpretative Statement: 2600.82 (c)- Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

3. Review the benefit of the Regulation, per RCG: Protects resident who are unable to safely use or avoid poisonous materials from illness, injury, or death related to misuse of accessible poisons.

4. Description of the Repair of the Immediate Problem: On 6/13/18 a new door lockset was installed which locks upon closure of door. The cabinet with chemicals was locked and key removed, RCS no longer have access to this cabinet a key for entry will be kept by Food Service Director and Food Service staff only to refill chemicals for dishwasher all other chemicals were removed and placed in locked mechanical closet.

5. Determine / document the Root Cause of the Violation: Management team did not have a procedure in place to monitor and verify that the kitchen remained locked at all times, consistent with knowledge of the regulations, or hold others accountable for the same.

6. Detail Action Steps / System Developed to prevent future occurrence:
   a. Teaching or Training? On 6/15/18 during a community staff training/meeting DCS was notified of new lock and procedures for why lock was changed. Regulation 2600.82 (c) was reviewed during this meeting. DRCS also reviewed poison substance in a memory care protocol from RCG's. Documentation of the meeting and attendance will be maintained. Please find attached meeting documentation and sign in sheet.
   b. On-going Monitoring? Maintenance, housekeeping, Food Service department and Executive Director will check several times daily all doors with chemicals and areas in the building containing chemicals for open/unlocked doors. Documentation of daily monitoring and findings will be maintained.

Authorized Signature Susan Day Date: 6-20-18

7. Designated position responsible and specify target date for correction. Environmental Services (ES), housekeeping and food service staff and ED by 6/15/18, Check list started 6/21/18

Authorized Signature Jessica Day Date: 6-20-18

Violation Report: 30767 - 06/06/2018 - Hoover, Douglas
PCH Name: MAGNOLIAS OF CHAMBERSBURG BLDG 1

1. REGULATION 55 Pa.Code §2600

2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION

The baseboard wall heater, across from room #10, had an end cap that had partially separated from the unit with a sharp metal corner protruding into the hallway.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See attached, Page 3A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Tressia Day

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tressia Day, Executive Director

Date 6-20-18

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 6/28/18 (Date)

The above plan of correction was approved by BAS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- [x] Fully implemented
- [ ] Partially implemented - Adequate Progress
- [ ] Partially implemented - Inadequate Progress
- [ ] Not implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg
License Number: 307670
Date of Visit: June 6, 2018
Date of Submission: June 20, 2018

1. Violation Review: The baseboard wall heater, across from room #10, had an end cap that had partially separated from the unit with a sharp metal corner protruding into the hallway.

2. Violation Interpretative Statement: 2600.95- Furniture and equipment must be in good repair, clean and free of hazards.

3. Review the benefit of the Regulation, per RCG: Furniture and equipment tat is clean, free of hazards, and in good repair helps to maintain sanitary conditions in the home and minimize the risk that residents will suffer an injury while using the furniture or equipment.

4. Description of the Repair of the Immediate Problem: Repair was made to the baseboard wall heater on 6/6/18 prior to DHS leaving the building.

5. Determine / document the Root Cause of the Violation: A wheeled chair or house keeping cart caught the edge of the baseboard wall heater and the heater end cap pulled away from the unit, the home's staff did not take notice of the sharp metal corner during rounds and building monitoring.

6. Detail Action Steps / System Developed to prevent future occurrence:
    a. On-going Monitoring? On daily rounds performed by Maintenance Supervisor, Housekeeping Assistants, and Executive Director and Designee, they will monitor baseboard heater (and all building equipment) to ensure they do not have protruding areas or areas that may be hazardous where a resident could receive injury it will be documented in morning stand-up meeting notes and MOD notes daily that building is safe, clean, and free from hazards or if a repair is need a work order will be provided to Environmental Services for repair in a timely fashion. All staff will report immediately if any furniture or equipment is in disrepair using the work slip protocol. A review of the work slip protocol was completed on 6/15/18 at staff meeting/training. Please find attached meeting documentation and sign in sheet.

7. Designated position responsible and specify target date for correction. All Staff by 6/15/18

Authorized Signature Jessica Day Date: 6-20-18

1. REGULATION 55 Pa.Code §2600

2600.254(c) - Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

2a. DESCRIPTION OF VIOLATION

On 6/6/18, the door to the home's kitchen was unlocked allowing access to residents and visitors in the home. A binder containing confidential information regarding resident meal intake charting was located on the counter.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See attached Pages 4A and 4B

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Tressia Day			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Tressia Day, Executive Director	Date	6-20-18	

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 6/28/18 (Date)

The above plan of correction was approved by KAS (Initials)

Plan of correction implementation status as of 6/28/18 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

PLAN OF CORRECTION

Community Name: Magnolias of Chambersburg
License Number: 307670
Date of Visit: June 6, 2018
Date of Submission: June 20, 2018

1. Violation Review: On 6/6/18, the door to the home's kitchen was unlocked allowing access to resident and visitors in the home. A binder containing confidential information regarding resident meal intake charting was located on the counter.

2. Violation Interpretative Statement: 2600.254 (c)- Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administer or the administrators designee, and upon request, to the Department or representatives of Area agency on Aging.

3. Review the benefit of the Regulation, per RCG: Storing resident records in a secure manner while also providing the resident records to individual with authorized access helps to protect the security and privacy of a resident's health information, as well as provide necessary information to those persons who oversee the care of a resident.

4. Description of the Repair of the Immediate Problem: The kitchen door where the binder was located with the meal intake charting was removed from the kitchen and is now stored in the locked Wellness Center, on 6/13/18 a new lock was installed that locks automatically with closure.

5. Determine / document the Root Cause of the Violation: DCS failed to follow regulations of securing resident's records by leaving closet unlocked after entering, management team did not have in place a procedure to ensure kitchen remained locked at all times.

6. Detail Action Steps / System Developed to prevent future occurrence:
   a. Maintenance, Activities, Resident Care, Food Service supervisors and Executive Director will check several times daily all areas in the building daily for open doors, logs, and tracking forms to ensure privacy and security of resident's records and personal information.
   b. On 6/15/18 during a community staff training/meeting DCS was notified of new lock and procedures for why lock was changed. Regulation 2600.254 (c) was reviewed during this meeting. Please find attached meeting documentation and sign in sheet.
   c. Management will check during community rounds for compliance, Documentation of daily monitoring and findings will be maintained.

Authorized Signature Tammi Day Date: 6-20-18

7. Designated position responsible and specify target date for correction. All management staff by 6/15/18

Authorized Signature Jessica Day Date: 6-20-18