pennsylvania
DEPARTMENT OF HUMAN SERVICES

June 21, 2019

Ms. Loriann Putzier
President & Chief Officer of Operations
Tithonus Lancaster LP
C/O Integracare Corporation
6600 Brooktree Court, Suite 1000
Wexford, Pennsylvania 15090

RE: Magnolias of Lancaster
1870 Rohrestown Road
Lancaster, Pennsylvania 17601
Certificate #: 322590

Dear Ms. Putzier:

As a result of the Department's Bureau of Human Services Licensing's annual licensing inspection on May 16, 2019 and May 17, 2019 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations 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.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
Violation Report

Violation Report

Facility Information

Name: *MAGNOLIAS OF LANCASTER* License Number: *322590*
Address: *1870 ROHRESTOWN ROAD, LANCASTER, PA 17601*
County: *LANCASTER* Region: *CENTRAL*

Administrator

Name: *Julia M. Seifried* Phone: *7175601100* Email:

Legal Entity

Name: *TITHONUS LANCASTER LP*
Address: *C/O INTEGRACARE CORP 6600 BROOKTREE COURT,SUITE 1000, PA, 15090*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/11/1997* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *54* Waking Staff: *41*

Inspection

Type: *Full* BHA Docket #: Notice: *Announced*
Reason: *Renewal,Incident*

Inspection Dates and Department Representative

05/16/2019 - On-Site: Laura Heemer, Hope O'Pake

05/17/2019 - On-Site: Laura Heemer, Hope O'Pake

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* Residents Served: *27*

Secured Dementia Care Unit

In Home: *Yes* Area: *Magnolias of Lancaster* Capacity: *38* Residents Served: *27*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *27*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *27*
Have Physical Disability: *1*

23a - Activities of Daily Living Assistance

Regulations

2600.

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

Description of Violation

The assessment and support plan dated 4/26/2019 for Resident 1 indicates the resident's need for supervision as "Extensive (requires regular supervision in the home and cannot leave home unattended; unaware of unsafe areas)" . This level of supervision was not provided to the resident on 5/7/19 when the resident exited the building and was walking across the home's lawn without staff being aware of the elopement.

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.)

Refer to pages 2A and 2B

Legal Entity Representative

Julia M Seifried — Julia M. Seifried — 06.05.19

Signature — Printed Name and Title — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 6/5/2019 (Date)

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

Plan of correction implementation status as of 6/19/19 (Date)

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

PLAN OF CORRECTION

Community Name: Magnolias of Lancaster

License Number: 322590

Date of Visit: 05.16.19 & 05.17.19

Date of Submission: 06.05.19

1. **Violation Review:** 2600.23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

2. **Violation Interpretative Statement:** The assessment and support plan dated 04.26.19 for Resident 1 indicates the resident's need for supervision as "Extensive (requires regular supervision in the home and cannot leave home unattended; unaware of unsafe areas)" .This level of supervision was not provided to the resident on 05.07.19 when the resident exited the building and was walking across the home's lawn without staff being aware of the elopement.

3. **Review the benefit of the Regulation, per RCG**: This regulation assists in ensuring the home is a safe place to reside and the indicated needs of a Resident are being met and protects the home from seeking admission to a home that cannot meet their needs and from permitting a resident who the home cannot serve safely.

4. **Determine / document the Root Cause of the Violation**: A process for transitioning the new resident at their assessed level of supervision was not in place as indicated on their RASP. Through the course of the subsequent investigation we have come to understand how our door alarm can be inadvertently "silenced" from the back panel in the break room and are currently working with Tyco: Simplex Grennell /Hershock's Inc. to rectify the issue. Improvement in our procedures for responding to "alarms" has been our focus.

5. **Detail Action Steps / System Developed to prevent future occurrence**: Resident was placed on one - hour checks for 48 hours, team members on all shifts met with the ED to review protocols for new Residents and protocols for responding to door alarm. The Resident's RASP was reviewed to determine if changes needed to be made to reflect the need for greater supervision.

6. **Detail Action Steps / System Developed to prevent future occurrence:**
   a. Changing practice? Based on a new Resident's assessment the need for supervision will be highlighted and reviewed with the team daily on every shift during the first seven (7) days of transition to their new living situation. Aspects of the Resident's Life Story will be highlighted to understand and offer suggestions for meeting the Residents' needs: physical, emotional, psychological, social.
   b. **Teaching or Training**? The Magnolias Team has been re-educated on the process that should utilized when the front door alarm sounds.

- A rapid response to the door alarm should occur to identify the reason the alarm has been sounded.
- Once the reason for the alarm has been identified, it will be corrected (i.e., the Resident to be redirected and involved in something other than the door). The door alarm will be silenced and the statement "Door Secure" should be announced over two-way communication for all.
- If the reason for the alarm cannot be identified, an immediate notification should be made to team members that a "Missing Resident" protocol will begin to ensure all Residents are accounted for.
- When any door alarm is activated no team member should leave the community through the exit door in break room or silence the alarm from the back panel until an "All Clear" has been sounded via two-way communication device mentioned above.
- This process will be trained on, with daily drill for reinforcement until a pattern of compliance with the procedures can be firmly established.

c. **On-going Monitoring**? ED/DRCS/All Members of the Management Team/All Direct Care Team/Service Workers

7. **Designated position responsible and specify target date for correction.** Executive Director Maintenance Supervisor beginning immediately. 05.08.2019 and on-going. This will be a focus at our 06.05.19 Quarterly All Team Meeting.

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff Person A did not have annual training related to fire safety and emergency preparedness during training year 2018.

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.)

Refer to Page 3A

Legal Entity Representative

Julia M Seifried — Julia M. Seifried, ED — 06.05.19

Signature | Printed Name and Title | Date

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PLAN OF CORRECTION

Community Name: Magnolias of Lancaster

License Number: 322590

Date of Visit: 05.16.19 & 05.17.19

Date of Submission: 06.05.19

1. Violation Review: 2600.65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

a. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

b. Emergency preparedness procedures and recognition and response to crises and emergency situation.

2. Description of Violation Staff Person A did not have annual training related to fire safety and emergency preparedness during training year 2018.

3. **Review the benefit of the Regulation, per RCG:** This regulation ensures that all staff who work in the home are reminded of the home's emergency procedures and mandated reporting requirements.

4. **Description of the Repair of the Immediate Problem**:
Training was conducted. Fire Safety Training - Live Training Including TTT & CCC Video, Fire Extinguisher Training, Community Walk Through, Hands on Practice of Fire System & Alarms, Fire Safe Zones, Evacuation Procedures & Routes have been scheduled for the following dates in 2019. Trainings will be available at various times so al team members can attend.

a. 2nd Quarter- June 25th: 2:00 pm/9pm/1:00 am
b. 3rd Quarter - September 25: 2:00 pm/9pm/1:00 am

5. **Determine / document the Root Cause of the Violation**: Inconsistent review / monitoring of Training deadlines to ensure all team members have completed mandatory trainings.

6. **Detail Action Steps / System Developed to prevent future occurrence**:

a. **Changing practice?** Review training plan quarterly to ensure all team members have completed or attended scheduled trainings.

b. **Teaching or Training?** Review 2019 Training Schedule with Team Members at Quarterly Meetings.

c. **On-going Monitoring**? ED/BOA has placed on the Leadership Teams' Microsoft Outlook Calendars in order to disseminate information to their team members. Team Members will receive notification via On-Shift reminders two weeks prior to training, 1 week prior to training and 2 days prior to training.

7. **Designated position responsible and specify target date for correction.** ED/Business Office Assistant will have the responsibility of monitoring the training tracker on a quarterly basis to identify team members who did not complete the required training for that quarter. Goal is that all live trainings will be completed prior to the end of the 3rd quarter of 2019.

185a - Implement Storage Procedures

Regulations

2600.

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

Description of Violation

The home did not implement its implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment as evidenced by:

1. A "house" glucometer was found on the medication cart. This glucometer had two blood sugar measurements stored in its memory. However, the home could not identify whose blood sugar was measured with the device.

2. The glucometer used by Resident 2 was incorrectly programmed to display a time and date of 1:19am on 1/27/19, when the actual time and date was 11:21am on 5/17/19.

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.)

Refer to Page 4A

Legal Entity Representative

Julia M Seifried — Julia M Seifried, ED — 06.05.19

Signature | Printed Name and Title | Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

PLAN OF CORRECTION

Community Name: Magnolias of Lancaster

License Number: 322590

Date of Visit: 05.16.19 & 05.17.19

Date of Submission: 06.05.19

1. **Violation Review: 2600.183b**: Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

2. **Violation Interpretative Statement:** The home did not implement its implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment as evidenced by:

   - A "house" glucometer was found on the medication cart. This glucometer had two blood sugar measurements stored in its memory. However, the home could not identify whose blood sugar was measured with the device.
   - The glucometer used by Resident 2 was incorrectly programmed to display a time and date of 1:19am on 1/27/19, when the actual time and date was 11:21am on 5/17/19.

3. **Review the benefit of the Regulation, per RCG**: Compliance of this regulation ensures the health, safety and wellbeing of all Residents residing in the home.

4. **Description of the Repair of the Immediate Problem**:
   - The "house" glucometer found on the medication cart was immediately discarded and 2nd "house" glucometer which was unopened was placed in a zip-lock bag and sealed. Noted on glucometer if utilized for a Resident that glucometer becomes the immediate property of that Resident and a new "house" glucometer must be ordered.
   - Resident #2's glucometer was programed immediately following surveyor's observation that it was not programmed with the correct date or time.

5. **Determine / document the Root Cause of the Violation**: Routine Tracking system was not implemented to verify consistent monitoring of the above policy.

6. Inconsistent utilization of Tracking system.

6. **Detail Action Steps / System Developed to prevent future occurrence:** Re-education of DRCS/ Medication Assistants on the storage/usage of diabetic Residents' equipment and their medications upon admission.
   a. **Changing practice?** Prior to first usage of a glucometer it will need to be checked to ensure that the date and time displayed are accurate.
   b. **Teaching or Training**? MA's will receive training on the storage/usage of diabetic equipment and medications on 06.05.19 by ED/DRCS. (See attached)
   c. **On-going Monitoring?** Weekly Resident glucometer checks.

7. **Designated position responsible and specify target date for correction.** ED/DRCS/MAs. Weekly beginning 05.31.2019.

234b - Support Plan Needs Elements

Regulations

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan for Resident 3, dated 4/18/2019, does not document Resident 3's medical diagnoses and the support services in place to address the needs associated with the diagnoses.

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.)

Refer to Page 5A

Legal Entity Representative

Julia M Seifried — Julia M Seifried, ED — 06059

Signature | Printed Name and Title | Date

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PLAN OF CORRECTION

Community Name: Magnolias of Lancaster

License Number: 322590

Date of Visit: 05.16.19 & 05.17.19

Date of Submission: 06.05.19

1. **Violation Review:** 2600.234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

2. **Violation Interpretative Statement** The support plan for Resident 3, dated 4/18/2019, does not document Resident 3's medical diagnoses and the support services in place to address the needs associated with the diagnoses.

3. **Review the benefit of the Regulation, per RCG:** Awareness of all areas of the support plan developed for the resident and to ensure that there is a plan in place to serve residents with challenging behaviors as soon as possible.
4. **Description of the Repair of the Immediate Problem:** Review Resident #3 's RASP and make necessary corrections. Re-print.
5. **Root Cause of the Violation:** The DRCS Insufficient understanding of the State Form used in the development of the RASP.
6. **Detail Action Steps / System Developed to prevent future occurrence:**
    - RASP will be printed and reviewed by DRCS/ED to ensure all criteria on the State Form are addressed in their entirety: Degree, Description of Service Need, Plan to Meet service Need, Frequency and Provider are addressed in their entirety.
    - RASP will then be finalized by signature of the Assessor and placed in Resident's chart following the review with all appropriate parties, and all signatures in place.
        a. **Changing practice?** Thorough review of individual Resident's RASP completed by ED/DRCS prior to printing & presenting to Resident/Responsible Party. Both the ED/DRCS will be sign the RASP.
        b. **Teaching or Training**? DRCS/ED will review RASP development with ICC Compliance Coordinators to gain a better understanding of RASP development.
        c. **On-going Monitoring?** Review of all RASP: Initial, Annual, Significant Chane prior to completion to locate any areas that are incomplete.
7. **Designated position responsible and specify target date for correction.** ED/DRCS
   Immediate implementation and on-going until compliance with the regulation can be demonstrated consistently.

*The ED and/or DRCS will complete an audit of all resident assessments and support plans (RASPs) to ensure that an accurate assessment of the current needs and abilities of each resident, and a description of how the needs of each resident will addressed by the home, has been documented. The audit and completion of any new RASPs shall be completed within 20 days from the receipt of this plan.

BAS 6/5/2019

234d - Support Plan Revision

Regulations

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident 2's current support plan, completed on 3/21/2019, did not document Resident 2's dietary needs for mechanical soft foods and nectar thick liquids as ordered by Resident 2's physician on 2/12/2019. This support plan was also not revised to include the home's plan to meet Resident 2's need for wound care.

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.)

Refer to Page 6A

Legal Entity Representative

Julia M Seifried Julia M Seifried 06.05.19

Signature | Printed Name and Title | Date

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PLAN OF CORRECTION

Community Name: Magnolias of Lancaster

License Number: 322590

Date of Visit: 05.16.19 & 05.17.19

Date of Submission: 06.05.19

1. Violation Review: 2600.234.d. The support plan shall be revised at least annually and as the resident's condition changes.

2. Violation Interpretative Statement: Resident 2's current support plan, completed on 3/21/2019, did not document Resident 2's dietary needs for mechanical soft foods and nectar thick liquids as ordered by Resident 2's physician on 2/12/2019. This support plan was also not revised to include the home's plan to meet Resident 2's need for wound care.

3. Review the benefit of the Regulation, per RCG: A person with Dementia has rapidly changing mental and physical health needs; a current support plan can assist in specifying 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 top address life safety issues and/or changing needs.

4. **Description of the Repair of the Immediate Problem**: Review Resident #2 's RASP to include both the dietary change and the need for wound care. Re-print.

5. **Root Cause of the Violation:** Resident 2's previous RASP should have been amended when the diet change order was received. This is going to be a function of comparing "significant" changes such as diet orders and going back to the RASPs to see if they are being placed onto the tool.

6. **Detail Action Steps / System Developed to prevent future occurrence:**
   - When completing an annual or significant change RASP all areas of change must be identified and addressed on the RASP utilizing notes from the Resident's Physician, OT/PT Speech Providers, Hospice Organizations, Care Notes, ad day to day observations.
     a. **Changing practice?** Thorough review of individual Resident's RASP prior to completion.
     b. **Teaching or Training**? DRCS/ED will review RASP development with ICC Compliance Coordinators to gain a better understanding of RASP development.
     c. **On-going Monitoring?** Review of all RASPS: Initial, Annual, Significant Change prior to completion to include any significant changes.
7. **Designated position responsible and specify target date for correction.** ED/DRCS. Immediate implementation and on-going.

*The ED and/or DRCS will complete an audit of all resident assessments and support plans (RASPs) to ensure that an accurate assessment of the current needs and abilities of each resident, and a description of how the needs of each resident will addressed by the home, has been documented. The audit and completion of any new RASPs shall be completed within 20 days from the receipt of this plan.

BAS 6/5/2019