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

October 6, 2023

[redacted], MBR
MAGNOLIA LEXI LLC
[redacted]

RE: MAGNOLIA PERSONAL CARE
CENTER-BUILDING I
68 LEXI STREET
MIFFLINTOWN, PA, 17059
LICENSE/COC#: 33870

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/13/2023, 06/14/2023, 06/15/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MAGNOLIA PERSONAL CARE CENTER-BUILDING I* **License #**: *33870* **License Expiration**: *03/22/2024*

Address: *68 LEXI STREET, MIFFLINTOWN, PA 17059*

County: *JUNIATA* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MAGNOLIA LEXI LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *01/29/1988* **Issued By**: *Labor & Industry*

Type: *C 2 LP* **Date**: *06/17/1991* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *23* **Waking Staff**: *17*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *06/16/2023*

Inspection Dates and Department Representative

06/13/2023 On Site: [redacted]
06/14/2023 On Site:
06/15/2023 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* **Residents Served**: *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *22*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

06/13/2023 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *07/16/2023*

08/01/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/15/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/08/2023*

08/14/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/15/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/21/2023*

10/05/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/15/2023*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for Resident #1 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 08/11/2023)***

On [redacted], Resident #1 signed the unsigned contract. On [redacted], Administrator/designee revised new contracts for all current and new residents. Administrator/designee will be responsible for having all contracts signed by the resident, designee/payer, if applicable, by [redacted]. Starting [redacted], Administrator/designee will create and institute a procedure whereas all contracts are witnessed and initialed by Administrator/designee and Property Manager to assure this violation does not recur. (Contract attached.)

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented ([redacted] - 08/15/2023)

25c4 - Payment Responsibility

2. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
4. The party responsible for payment.

Description of Violation

The resident-home contract , dated [redacted], for Resident #1 does not specify the party responsible for payment. The payment section II.A. of the contract is blank.

Plan of Correction ***Accept ([redacted] - 08/11/2023)***

On 6/16/2023, Administrator/designee completed section II.A. of Resident #1 home-contract. On 7/14/23, Administrator/designee revised new contracts for all current and new residents. Administrator/designee will be responsible for having all contracts signed by the resident, designee/payer, if applicable, by 8/31/23. Starting 7/15/23 Administrator/designee will create and institute a procedure whereas all contracts are witnessed and initialed by Administrator/designee and Property Manager to assure this violation does not recur. (Contract attached.)

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented [redacted] - 08/15/2023)

26a - Quality Management Plan

3. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home has a policy that the Quality Management Plan shall be reviewed annually. The last quality management plan review was held on 11/19/2021.

26a - Quality Management Plan *(continued)*

Plan of Correction ***Accept (- 08/11/2023)***

On 6/17/2023, Administrator/designee created an electronic reminder for two months prior to the due date, 04/15/2024, to ensure that the Quality Management Plan review will occur at least annually. The Quality Management Plan was last reviewed 06/15/2023 by Administrator/designee and Property Manager. (Quality Management Plan and reminder are attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented (- 10/05/2023)

51 - Criminal Background Check

4. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member C maintains a permanent residence outside of Pennsylvania, and requires a report of federal criminal history record information from the Federal Bureau of Investigation (FBI Check) as per the Older Adult Protective Services Act (OAPSA). There is no record of an FBI check being performed nor requested for Staff Member C in their file.

Plan of Correction ***Accept (- 08/11/2023)***

On , Staff member C completed the FBI clearance check. Results of the FBI clearance check were placed in Staff member C's file on . On 7/16/23, Administrator/designee educated hiring staff of hiring documentation requirements for all employees as it pertains to Regulation 51. By 08/01/2023, Administrator/designee and the Property Manager will review all existing and new staff files to ensure all staff files have all required documentation and that if they have not lived in PA for two years, that they must have an FBI clearance check. Starting 6/17/23, Administrator will create and implement a hiring policy whereby all employees will be required to either state that they have lived in PA for two years or perform the required FBI clearance check as per the Older Adult Protective Services Act. (Proof of FBI check attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented (- 09/15/2023)

56 - Admin 20 Hours/Week

5. Requirements

2600.

56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

Description of Violation

During calendar months of April and May 2023 the Administrator, , was not present in the home for an average of 20 hours or more per week.

Plan of Correction ***Accept (- 08/11/2023)***

Starting 6/16/23, Property Manager will keep a detailed record to verify Administrator hours spent on the property. In addition, Administrator will hold two weekly Zoom meetings with Administrator/designee and Property Manager

56 Admin 20 Hours/Week (continued)

to ensure good communication when not on property. Additionally, Administrator/designee will be on premise at least 40 hours per week. Administrator, Administrator/designee, and Property Manager communicate daily.

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented ([redacted] - 10/05/2023)

85e - Trash Outside Home

6. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

O6/14/23, the regular trash dumpster was observed to be full and the corner lid is sticking up due to debris and full trash bags atop the debris. In addition, the cardboard recycling container has no lid at all, and on 6/15/23, it is overflowing and includes at least seven cardboard pizza boxes which have grease and various food debris.

Plan of Correction ***Accept ([redacted] - 08/11/2023)***

On 6/15/2023, Property Manager ordered a lidded cardboard dumpster. Starting 6/15/23, the service to empty trash dumpsters has been increased to twice weekly to prevent overflow. On 6/23/23, Administrator/designee performed a staff in service regarding dumpster utilization and breakdown of boxes. On 7/15/23, trash company delivered an additional lidded cardboard dumpster. Starting 7/15/23, Administrator/Maintenance will perform daily walk throughs of property to ensure that all receptacles are covered. By 8/8/2023, Administrator/designee will create and maintain an audit sheet to document and verify that these walk throughs are being performed and the results are recorded. (Sign in sheet, photo and audit sheet attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented [redacted] - 10/05/2023)

102k - No Common Towel

7. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

There was a used towel in the shared bathroom of Resident #4. There are two towel racks in this bathroom, one has towels one has washcloths, neither are labeled. There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in this bathroom. Interviews with the residents confirmed that the residents use the towels in this bathroom interchangeably.

Plan of Correction ***Accept ([redacted] - 08/11/2023)***

On 6/14/2023, the towels in the bathroom of Resident #4 were taken to the laundry by Housekeeping. On 6/14/2023, Housekeeping placed single use pull towels is Resident #4's bathroom. On 6/19/2023, Maintenance installed towel rings/racks for each resident and the Property Manager labeled all rings/racks with each resident name. Administrator/designee will perform a daily walk through to check every shared bathroom for two weeks to verify that there are no shared towels being used. After the initial two week period, a walk through will be performed bi weekly for eight additional weeks, and then a weekly walk through for the next six months. On 8/7/23, Property Manager developed and implemented an audit sheet to record these audits and will discuss at the next quality

102k - No Common Towel (continued)

management meeting to be held no later than 9/30/2023. (Audit sheet and sign-in sheet attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented [redacted] - 08/21/2023)

141a - Medical Evaluation

8. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1 was admitted to the home on [redacted]. However, the date the resident's medical evaluation was completed was on [redacted], more than 60 days prior to the date of admission.

Plan of Correction ***Accept ([redacted] - 08/14/2023)***

On 6/17/2023, Administrator/designee developed a spreadsheet to monitor DME dates, to be checked monthly by Administrator/designee. By 8/15/2023, Administrator/designee and Property Manager will check all resident charts to ensure all residents ae current. Administration was in-serviced virtually by the Company COO on 6/23/23. (Spreadsheet and sign-in sheet attached.)

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 08/21/2023)

144c2 - Smoking Area Distance

9. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home's policy states that it is a non-smoking facility. The home's policy does not directly address electronic cigarettes or vaping. However, on [redacted], at approximately [redacted], a female resident was observed standing outside of Building 1 across from the dumpster area using a vaping device. There is no designated smoking area on the grounds of the facility. The area where the vaping occurred is directly in the path of common walkways and exits.

Plan of Correction ***Accept [redacted] - 08/14/2023)***

On 7/15/2023, Administrator/designee updated the smoking policy to include vaping and smokeless tobacco. On 7/15/2023, Maintenance posted a designated area, away from common areas, for vaping/smokeless tobacco. On 7/11/2023, Administrator/designee in-serviced residents concerning the new policy. Failure to comply with smokeless tobacco/vaping rules will result in written warning, followed by 30-day notice. (Sign and sign-in sheet attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented [redacted] - 08/21/2023)

162c Menus Posted

10. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

During the walk-through inspection conducted on 6/13/23, the most recent week of menus posted was for the week of 4/2-4/8/2023.

Plan of Correction ***Accept ([redacted] - 08/14/2023)***

On 6/14/23, Kitchen staff removed all old, outdated menus and posted current menus for the current week and one week in advance. Starting 6/14/23, Kitchen staff will perform daily walk throughs to verify that all required menus are posted for 3 weeks, then weekly for 6 weeks. On 8/7/23, Administrator/designee created an audit sheet to confirm the walk throughs and will record the results and discuss at the next quality management meeting to be held no later than 9/30/23. Direct care, Kitchen staff, & housekeeping were in-serviced on 6/23/23 regarding Regulation 162c. (Audit sheet and sign-in sheet attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented ([redacted] - 08/21/2023)

183b Meds and Syringes Locked

11. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 6/14/23 at approximately 10:00 am, the medication room in the building was unlocked and the door was open. Inside the room were two medication carts. The one to the left as you enter was secured and locked. However, the medication cart on the left side of the room containing treatments and glucometers was unlocked, unattended, and accessible.

Plan of Correction ***Directed ([redacted] - 08/14/2023)***

On 7/1/2023, Maintenance installed a pass-coded doorknob on the medication room. On 6/23/2023, Administrator/designee in serviced staff regarding the door locking mechanism and Regulation 183b. In-service included importance of keeping all medication/medical equipment locked at all times. (Photo attached.)

(Directed)

- On 7/1/2023, Maintenance installed a pass-coded doorknob on the medication room.
- On 6/23/2023, Administrator/designee in serviced staff regarding the door locking mechanism and Regulation 183b. In-service included importance of keeping all medication/medical equipment locked at all times. (Photo attached.)
- Starting 9/1/23 - Administrator/Maintenance/Designee will perform a daily walk-through for two weeks to verify that the Med Room is consistently closed and locked. After two weeks, this walk-through will be performed weekly for eight additional weeks. Administrator will design and complete and audit sheet for documentation.

183b Meds and Syringes Locked *(continued)*

Directed Completion Date: *08/09/2023*

Implemented [redacted] - 10/05/2023)

183f - Discontinued Medications

12. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

During interviews with multiple staff persons who handle medications, it was determined that the normal course of action for medications that become loose or are refused by a resident after removal from the packaging is that they are flushed down the commode". This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction ***Accept ([redacted] - 08/14/2023)***

On 6/23/23, Administrator/designee in serviced all staff, in person, concerning medication disposal procedures and Regulation 183f. All loose, discarded, or refused meds will be disposed of in accordance with state regulations. Medication carts to be checked daily by med staff for loose medication. To prevent this violation in the future the Administrator/designee will include an explanation of 2600.183.f to new employee training packets and will be subject matter in future staff meetings. (Sign in sheet attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented [redacted] - 08/21/2023)

185a - Implement Storage Procedures

13. Requirements

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

Description of Violation

On [redacted] at [redacted] am, the Glucometer for Resident #2 showed the correct date, but the time of [redacted]. Resident #2 is prescribed a blood sugar check at [redacted] am each day. The glucometer audit showed the [redacted] reading documented as [redacted] on the log, this reading was not present on the glucometer. Further, the [redacted] reading documented as [redacted] was actually taken at approximately [redacted] am on [redacted] the [redacted] reading documented as [redacted] was actually taken at approximately [redacted] on [redacted] and the [redacted] reading documented as [redacted] was actually taken at approximately [redacted] on [redacted]. Finally, the [redacted] reading documented as [redacted] was actually taken at approximately [redacted] on [redacted].

185a Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (- 08/14/2023)***

Administrator/designee in serviced all med staff on 6/23/23 on Regulation 185a and the importance of accurate and timely glucometer readings. On 6/21/23, Administrator/designee developed and implemented a biweekly audit sheet for all glucometers. Administrator/designee calibrated all glucometers to the correct date and time on 6/21/23. Starting 6/21/23, Administrator/designee will conduct the glucometer audits biweekly indefinitely. Starting 8/7/2023, Staff member responsible for the incorrect readings was re trained by a Certified Diabetic Educator on 7/18/2023. The results of these audits will be kept and discussed at the next quality management meeting to be held no later than 9/30/23. (Audit sheet, sign in sheets and Diabetic educator document attached.)

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented (- 08/21/2023)

224a - Preadmission Screen Form

14. Requirements

2600.
224.a. 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.

Description of Violation

Resident #1's preadmission screening form, dated , is incomplete, in that it does not include any medical, psychological or behavioral diagnoses.

Plan of Correction ***Accept (- 08/14/2023)***

On Administrator/designee corrected the pre admission screening form for Resident #1. Administrator/designee will review all resident screening forms by . Starting , all pre admission screening forms will be double checked for completeness and accuracy by both the Administrator/designee and the Property Manager and will be verified by initials. Any errors or missing/incomplete information will be immediately corrected before being initialed and dated.

Licensee's Proposed Overall Completion Date: *08/09/2023*

Implemented - 10/05/2023)