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 III
68 LEXI STREET
MIFFLINTOWN, PA, 17059
LICENSE/COC#: 33871

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/14/2023, 06/15/2023, 06/16/2023 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 III* **License #**: *33871* **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]

Phone: [redacted] **Email**: [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**: *6* **Waking Staff**: *5*

Inspection Information

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

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

Inspection Dates and Department Representative

06/14/2023 - On-Site: [redacted]

06/15/2023 - On-Site:

06/16/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *7* **Residents Served**: *6*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older**: *4*

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

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

Inspections / Reviews

06/14/2023 Full

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

Inspections / Reviews *(continued)*

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: *JAMIE SWARTZ* **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*

26a - Quality Management Plan

1. 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.

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

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 [redacted] - 10/05/2023)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On 6/13/23, upon entry to the far-right apartment , there is an odor of urine. In the bathroom, there is a puddle of liquid in front of the toilet which appears to be urine; there also appears to be urine in the bowl as when flushed, the color of the liquid changes from a yellowish to clear. After further discussion throughout the inspection, it appears that Resident #1 who resides with a roommate in this apartment frequently "misses" the commode. Interviews show that these occurrences happen daily, and need to be cleaned up by staff at least three times a day.

In the same apartment, there is an overstuffed light-brown microfiber chair in the living area which is heavily soiled with stains, covered with dirty towels and littered with crumbs and other loose debris, leading to unsanitary conditions in the apartment.

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

Administrator will complete weekly walkthroughs starting 6/14/23 and they will continue indefinitely. Walk through of facilities will be to ensure that furniture, beds, and other items are clean and in good repair. Soiled and other items in poor condition will be disposed of and replaced with clean items. On 6/23/23, Administrator in-serviced all staff regarding Regulation 2600.85.a. and apartment check procedures. All staff are to report any soiled, unsanitary, and damaged items immediately. (Sign-in sheet audit sheet attached.)

(Directed)

- On 6/13/23, Administrator directed care staff to immediately clean the urine from the floor of the bathroom in apartment. In addition, care staff removed and washed the cover of the brown recliner in same apartment.
- On 6/23/23, Administrator in-serviced all staff regarding Regulation 2600.85.a. and apartment check procedures. All staff are to report any soiled, unsanitary, and damaged items immediately. (Sign-in sheet audit sheet attached.)

85a - Sanitary Conditions (continued)

- Administrator will complete weekly walkthroughs starting 6/14/23 and they will continue indefinitely. Walk through of facilities will be to ensure that furniture, beds, and other items are clean and in good repair. Soiled and other items in poor condition will be ***EITHER IMMEDIATELY CLEANED OR*** *disposed of and replaced.*

Directed Completion Date: *08/31/2023*

Implemented ([redacted] - 08/22/2023)

85e - Trash Outside Home

3. 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 is 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] - 08/14/2023)***

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)

88a - Surfaces

4. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The bathroom of the center apartment has a baseboard heater that is heavily covered in rust.

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

On 6/16/23, Maintenance removed the rust from the baseboard in Apt 2, repainted and replaced. Maintenance was in-serviced by Administrator on 6/23/23 regarding Regulation 2600.88.a. Maintenance will monitor all surfaces to make sure they are in good condition and free of hazards. Starting 6/16/23, Administrator will perform weekly inspections of al bedrooms, bathrooms, common areas, etc. to ensure facility is clean and in good repair. Any area of concern will be documented and immediately repaired. (Sign-in sheet, and photo attached.)

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

Implemented [redacted] - 08/22/2023)

102i - Soap Dispenser

5. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

The left apartment has a bathroom that is shared by two female residents. There was a thin, white, unlabeled used bar of soap to the left of the bathroom sink in the shared bathroom.

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

On 6/14/23, the bar soap was disposed of in Apartment 1. On 7/01/23 Housekeeping replaced all bar soap with liquid soap. On 6/23/23, all staff were in-serviced on remise on the discontinuation of bar soap Any bar soap will be disposed of immediately if found. Care Staff/Housekeeping will make sure there is always liquid soap available in all bathrooms at all times. Housekeeping will perform daily walk throughs of each bathroom in each apartment to verify that there are no bar soaps being used in shared bathrooms for two weeks. Following this, these checks will be performed three times per week for eight weeks, and weekly thereafter or when residents move in/out. Administrator will develop an audit sheet to track these walk throughs and will be discussed at the next quality management meeting to be held no later than 9/30/23. (Sign-in sheet and audit sheet attached.)

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

Implemented ([redacted] - 08/22/2023)

102k - No Common Towel

6. Requirements

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

Description of Violation

The center apartment has a bathroom that is shared by two male residents. There were three used towels in the shared bathroom on an unlabeled towel bar. There were no paper towels, mechanical hand dryer or other sanitary means of hand/body drying in this bathroom. There was nothing to delineate or identify the placement of towels to prevent common towel usage.

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

On 6/14/2023, the towels in the Apt 2 bathroom were taken to the laundry by Housekeeping. On 6/14/2023, Housekeeping placed single use pull-towels is Apt 2 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 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] - 08/22/2023)

103e - Left Overs

7. Requirements

103e - Left Overs *(continued)*

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The far-right apartment has a small eat in kitchen with a sink and refrigerator. On 6/13/23, there was an uncovered, unlabeled and undated plate of leftover food consisting of what appeared to be meatloaf, scalloped potatoes, carrots and broccoli on the top shelf of the refrigerator.

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

On 6/14, Care Staff disposed of leftover food in the refrigerator of Apartment three and took the soiled dishes to the kitchen in Building two to be washed and sanitized. On 6/23/23, Administrator in-serviced all staff on the correct storage and disposal of leftover food. All food will be covered, properly stored, and dated. All soiled dishes will be removed by Care Staff daily. Administrator will perform daily Apartment audits to prevent recurrence. (Audit sheet attached.)

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

Implemented (- 08/22/2023)

103j - Utensils Cleaning

8. Requirements

2600.
103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

Description of Violation

The far-right apartment has a small eat in kitchen with a sink and refrigerator. The apartment does not have an operable dishwasher. During the inspection on 6/13/23, the kitchen area is full of between 10-15 used / heavily soiled dishes either in the sink or on the counter.

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

On 6/14/23, Care Staff removed all soiled dishes from Apartment three to the kitchen in Building two to be cleaned and sanitized. On 6/23/23, Administrator in-serviced all staff on Regulation 103j. Staff were reminded that all meals for Building three are to be served in either Building one or Building two. Starting 6/14/23, Administrator will perform daily audits on all three apartments to assure regulations are not violated. On 8/7/23, Administrator created and implemented a daily audit sheet to verify compliance. (Sign-in sheet and audit sheet attached.)

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

Implemented (- 08/22/2023)

131a - Fire Extinguisher

9. Requirements

2600.
131.a. There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

Description of Violation

The attic area for the entire building is

131a - Fire Extinguisher (continued)

accessible through a set of pull-down steps located in the right apartment. The attic contains numerous boxes and personal belongings. There was no fire extinguisher present in the attic level of the home.

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

On 6/14/23, Property Manager ordered three fire extinguishers, one for each attic of all three buildings. On 6/15/23, Fire Company delivered and installed a fire extinguisher in the attics of all three buildings. On 6/23/23, Maintenance was in-serviced on Regulation 131a. On 6/15/23, the attic fire extinguishers were added to the monthly fire extinguisher inspections and included in the annual fire drill inspection by the Fire Chief. (Sign-in sheet and work acknowledgement attached.)

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

Implemented (- 08/22/2023)

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 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 - 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 (- 08/22/2023)

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 6/13/23, the following medications were found in living room area of the far-right apartment: a 17.9 oz bottle of [redacted] underneath a side table and a [redacted] removal on the side table. Both of these were found unlocked, unattended, and accessible.

The following medications were also found in the bedroom of the left apartment: a bottle of Dollar General brand [redacted]. All of these medications were found unlocked, unattended, and accessible. No one in the apartments have been approved to self-administer any medications.

183b - Meds and Syringes Locked (continued)

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

On 6/14/23, medication found in Apartment 1 and Apartment 3 was removed from the Apartments by the Administrator. Administrator received PRN orders for the medications and all medications were placed in the medicine cards in the appropriate building. All staff were in-serviced on 6/23/23 regarding Regulation 183b. and self-administration regulations. Residents and families were all notified of the OTC policies and requirements that all medications are to be locked at all times. Starting 6/16/23, Administrator/designee will perform daily walk throughs of the apartments to verify that there are no unlocked and accessible medications in resident's rooms for 2 weeks followed by bi-weekly walk throughs for 8 additional weeks, then weekly walk throughs indefinitely. On 6/23/23, Administrator in-serviced all staff regarding Regulation 183b. All medication will be locked in the medication carts at all times. (Sign-in sheet and audit sheet attached.)

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

Implemented (- 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 people 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 (- 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 (KB - 08/22/2023)

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 at , the glucometer for Resident # 1 showed a time of . All glucometers must be

185a - Implement Storage Procedures (continued)

calibrated to the correct date and time.

The blood sugar reading recorded on the Log Sheet for Resident # 1 on [redacted] is [redacted] However, the glucometer has a reading of [redacted]. Also, the blood sugar reading recorded on the Log Sheet for Resident # 1 on [redacted] is [redacted] However, the glucometer has a reading of [redacted] Further, the Log Sheet for Resident #1 shows [redacted] on [redacted] on [redacted] on [redacted] on [redacted] and [redacted] on [redacted]. However, the glucometer for this resident has no recorded reading for these dates.

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

On [redacted] Administrator/designee calibrated Resident #1's glucometer to the correct time. Staff member responsible for incorrect readings was given a two-week suspension and re-trained by a Certified Diabetic Educator on [redacted] before being permitted to take glucose readings. Administrator calibrated all glucometers to the correct date and time on [redacted]. On [redacted], Administrator/designee developed and implemented a biweekly audit sheet for all glucometers. Starting [redacted]3, Administrator/designee will conduct the glucometer audits biweekly indefinitely. The results of these audits will be kept and discussed at the next quality management meeting to be held no later than [redacted].Administrator/designee in-serviced all med staff on [redacted] on Regulation 185a and the importance of accurate and timely glucometer readings. (Audit sheet, sign-in sheets and Diabetic educator document attached.)

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

Implemented ([redacted] - 08/22/2023)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #1 is prescribed a blood sugar test once daily. However, Resident #1 did not receive this blood sugar test on [redacted]

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

On [redacted] Administrator/designee in-serviced all med staff regarding Regulation 187d, including proper reporting procedures for medication and following correct orders on the MARs. Starting 8/7/23, Administrator/designee will perform random MAR audits specific to residents with sliding scale insulin twice a week for four weeks and weekly for an additional eight weeks to ensure that insulin is being calculated, administered, and documented appropriately. (Sign-in sheet and audit sheet attached.)

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

Implemented ([redacted] - 08/22/2023)

227d - Support Plan Medical/Dental

15. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessments for Resident #1, dated both [redacted] and [redacted] indicate that the Resident is independent with toileting, bladder and bowel management and is independent with using proper judgement. Also, that [redacted] requires no supervision in the home or community. Interviews with both Administration and multiple staff show that this resident has had and continues to have issues with frequent urination on the floor of both public and private bathroom facilities to the point where staff are required to clean up after him multiple times daily. Neither of the Resident's support plans, dated 3/26/23 or 3/28/22 address this issue or how this need will be met appropriately.

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

On [redacted], Administrator/designee updated the RASP for Resident #1 to reflect accurate information regarding [redacted] bladder needs. On [redacted], Administrator/designee in-serviced all staff on Regulation 227d. Administrator/designee is working along with Physician to correct Resident #1 bathroom behavior. Physician will continue to re-evaluate Resident # 1 on a bi-weekly basis until issue is resolved. Resident #1 behavior has improved significantly. On 6/17/2023, Administrator/designee created and implemented a behavior log to record Resident #1 behaviors. On 6/23/2023, all staff were in-serviced on the new behavior log procedure. (Behavior log attached.)

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

Implemented [redacted] - 10/05/2023)