

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

July 7, 2023

[REDACTED], MEMBER
MAGNOLIA PLACE MANAGEMENT LLC
[REDACTED]
[REDACTED]

RE: MAGNOLIA PLACE OF SAXONBURG
100 BELLA COURT
SAXONBURG, PA, 16056
LICENSE/COC#: 45090

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/08/2023 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]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MAGNOLIA PLACE OF SAXONBURG* License #: *45090* License Expiration: *02/20/2024*
 Address: *100 BELLA COURT, SAXONBURG, PA 16056*
 County: *BUTLER* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *MAGNOLIA PLACE MANAGEMENT LLC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: <i>C 2 LP</i>	Date: <i>11/19/1997</i>	Issued By: <i>Dept L & I</i>
Type: <i>C 2 LP</i>	Date: <i>08/29/1994</i>	Issued By: <i>Dept L & I</i>
Type: <i>I 1</i>	Date: <i>02/14/2023</i>	Issued By: <i>Saxonburg Borough</i>

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *86* Waking Staff: *65*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint* Exit Conference Date: *06/08/2023*

Inspection Dates and Department Representative

06/08/2023 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* Residents Served: *59*

Secured Dementia Care Unit

In Home: *Yes* Area: *Magnolia Village* Capacity: *32* Residents Served: *21*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>59</i>
Diagnosed with Mental Illness: <i>1</i>	Diagnosed with Intellectual Disability: <i>2</i>
Have Mobility Need: <i>27</i>	Have Physical Disability: <i>3</i>

Inspections / Reviews

06/08/2023 - Partial

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

Inspections / Reviews *(continued)*

07/06/2023 - POC Submission

Submitted By: *Christal Ostrowski*

Date Submitted: *07/07/2023*

Reviewer: *Jonathan Weaver*

Follow-Up Type: *Document Submission* **Follow-Up Date:** *09/15/2023*

07/07/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *07/07/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED]/23, at approximately [REDACTED] p.m., staff person A asked for assistance with a resident via [REDACTED] walkie. Staff person B entered the unit and observed staff person A and resident #1 standing in the entryway of resident #1's former bedroom. Staff person A was holding resident #1 by the forearm, yelling "this isn't your room" while trying to pull the resident out of the bedroom. Resident #1 was observed as physically shaking and stating "[REDACTED] is going to hurt me. I'm so glad you're here". Resident #1 was observed to have a skin tear re-open and a small fingernail-like tear on the residents left forearm.

Plan of Correction

Accept ([REDACTED] - 07/06/2023)

- On [REDACTED]/23 at approximately [REDACTED] p.m. staff person B immediately intervened and redirected staff person A away from resident #1, provided resident #1 with comfort, reassurance and support. Staff person B immediately reported incident to LPN Support Nurse. PCHA immediately notified. On [REDACTED]/23 at approximately [REDACTED] p.m. LPN Support Nurse and PCHA arrived at facility removed staff person A from building, suspended staff person A without pay pending investigation outcome. Resident assessed, skin care provided, physician and responsible party notified. Internal investigation initiated. PCHA completed oral and written reports to the Area Agency on Aging and DHS BHSL. Skin care orders received from physician [REDACTED]/23. Protective services specialist onsite [REDACTED] 23 unsubstantiated. Resident seen by physician [REDACTED] 23 for follow-up. BHSL representatives onsite [REDACTED]/23 substantiated.
- Staff person A employment terminated [REDACTED]/23 at [REDACTED] 2 p.m. via phone by RSD and PCHA.
- Beginning 6/9/23 LPN Support Nurse, Resident Services Director, Administrator and/or Designee will meet with two residents weekly through 8/25/23 to verify regulatory compliance. Audit tool will be maintained.
- By 7/5/23 all DCS will be re-educated on 2600.42(b) by Resident Services Director and PCHA.
- Area Agency on Aging to conduct mandatory abuse training with all DCS on 7/21/23.
- Beginning 9/1/23 LPN Support Nurse, Resident Services Director, Administrator and/or Designee will meet with four residents a month thereafter to verify regulatory compliance. Audit tool will be maintained.

Licensee's Proposed Overall Completion Date: 08/25/2023

Implemented ([REDACTED] - 07/07/2023)

42c - Treatment of Residents

2. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [REDACTED]/23, at approximately [REDACTED] p.m., staff person A and staff person C were assisting resident #2 with a night time routine at bedside. Resident #2 was agitated when staff took off the residents shirt. Staff left the shirt with the resident to calm and distract this resident during care. Resident #2 said "please go, you're not welcome" while pushing staff person A with the back of [REDACTED] hand. Staff person A smacked resident #2 on the right hand with the back of staff person #A's hand and stated "that's not what we do" then said "that was a funny high five".

Plan of Correction

Accept ([REDACTED] - 07/06/2023)

42c - Treatment of Residents (continued)

- On [REDACTED]/23 at approximately 8:30 p.m. staff person C immediately redirected staff person A and reported the incident to LPN Support Nurse. LPN Support Nurse immediately notified PCHA. On [REDACTED]/23 at approximately 10:00 p.m. LPN Support Nurse and PCHA arrived at facility removed staff person A from building, suspended staff person A without pay pending investigation outcome. Resident assessed, physician and responsible party notified. Internal investigation initiated. PCHA completed oral and written reports to the Area Agency on Aging and DHS BHSL. Protective services specialist onsite [REDACTED]/23 unsubstantiated. Resident seen by physician [REDACTED]/23 for follow-up. BHSL representatives onsite [REDACTED]/23 substantiated.
- Staff person A employment terminated [REDACTED] 23 at [REDACTED] p.m. via phone by RSD and PCHA.
- Beginning 6/9/23 LPN Support Nurse, Resident Services Director, Administrator and/or Designee will meet with two residents weekly through 8/25/23 to verify regulatory compliance. Audit tool will be maintained.
- By 7/5/23 all DCS will be re-educated on 2600.42(c) by Resident Services Director and PCHA.
- Area Agency on Aging to conduct mandatory training with all DCS on 7/21/23.
- Beginning 9/1/23 LPN Support Nurse, Resident Services Director, Administrator and/or Designee will meet with four residents a month thereafter to verify regulatory compliance. Audit tool will be maintained.

Licensee's Proposed Overall Completion Date: 08/25/2023

Implemented ([REDACTED] - 07/07/2023)