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

February 14, 2024

[redacted], EXECUTIVE OPERATIONS OFFICER
TITHONUS LANCASTER, LP
[redacted]

RE: MAGNOLIAS OF LANCASTER
1870 ROHRESTOWN ROAD
LANCASTER, PA, 17601
LICENSE/COC#: 32259

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/28/2023, 11/28/2023 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: *MAGNOLIAS OF LANCASTER* **License #**: *32259* **License Expiration**: *07/21/2024*

Address: *1870 ROHRESTOWN ROAD, LANCASTER, PA 17601*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *TITHONUS LANCASTER, LP*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/24/1998* **Issued By**: *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *52* **Waking Staff**: *39*

Inspection Information

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

Reason: *Renewal, Complaint, Incident, Interim* **Exit Conference Date**: *11/30/2023*

Inspection Dates and Department Representative

11/28/2023 - On-Site: [redacted]

11/28/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served**: *26*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *38* **Residents Served**: *26*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *26*

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

Have Mobility Need: *26* **Have Physical Disability**: *0*

Inspections / Reviews

11/28/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/22/2023*

Inspections / Reviews *(continued)*

12/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/22/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/05/2024*

01/09/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/22/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/19/2024*

02/14/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/22/2024*

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] at [redacted] a Hospice Social Worker witnessed Resident 1 grab and twist Resident 2's right wrist, and forearm, and strike Resident 2 in the right temple.

The [redacted] Resident Assessment and Support Plan (RASP) indicates that Resident #1 requires "moderate" supervision and "requires some supervision in the home and needs attendance when outside the home, and/or tends to wander." The RASP also indicates that the resident is a "Fall Risk" and that the interventions provided by the home should be, in part, "Escort resident to meals and activities," "Remind resident to use Cane/Walker/Wheelchair as needed," "Verbally remind resident to ask for assistance when ambulating," "orally prompt to move from location to another" and "Assist with moving from one location to another." The home failed to provide appropriate supervision and assistance to Resident #1, resulting in falls on the following dates:

On [redacted] at [redacted], Resident 1 had an unwitnessed fall off a bench resulting in the resident suffering skin tear to the right elbow. Resident 1 was transported to the hospital for evaluation following this fall.
On [redacted] at [redacted], Resident 1 had an unwitnessed fall in the dining room. Resident 1 fell backwards into a wall, hit [redacted] head, and suffered a bruised hand. Resident 1 was transported to the hospital for evaluation following this fall.
On [redacted] at [redacted], Resident 1 was found on the ground in the outdoor courtyard, a swollen area observed on the right side of the resident's forehead. Resident 1 was transported to the hospital for evaluation following this fall.
On [redacted] at approximately [redacted], Resident 1 had an unwitnessed fall and was found on the floor on [redacted] right side.
On [redacted] at [redacted], Resident 1 had an unwitnessed fall and was found on the floor next to [redacted] bed.
On [redacted] at [redacted], Resident 1 had an unwitnessed fall and was found on the floor on [redacted] right side.
On [redacted] at [redacted], Resident 1 was observed by staff losing his balance, and hitting [redacted] head against the wall, and falling to the ground. Resident 1 was transported to the hospital for evaluation following this fall.
On [redacted] at [redacted] Resident 1 was walking down the hall with a staff member, [redacted] began losing [redacted] balance, both the resident and the staff member fell to the floor.
On [redacted] at [redacted], Resident 1 had an unwitnessed fall and was observed lying on the floor on [redacted] right side in the TV room in front of of a recliner.

Plan of Correction ***Accept ([redacted] - 01/09/2024)***

• On 10/16/23, upon learning of the incident, staff immediately redirected Resident 1 and evaluated both residents for injury. PCP and POA for both residents were notified, none were noted.
o Prompts and reminders were provided to the Resident 1 and he was redirected from Resident 2.
o Resident 1 was able to move without assistance and had a diagnosis of dementia.
o Resident 1 at times ambulated or stood from a seated position independently when staff were not directly beside him resulting in falls.
• On 10/17/23, the EOO submitted a verbal report to Lancaster County AAA.

42b Abuse (continued)

• On 10/18/23 then a report to DHS was send and on 10/19/23 an Act 13 Form was completed and sent to Lancaster County AAA.
• By 1/18/23, All Staff will receive education on following topics related to the violation:
o Abuse and Neglect definitions
o How to prevent abuse
o The processes for reporting abuse and neglect
o Falls prevention
o Following and understanding a resident RASP
• During scheduled staff meetings, The EOO or Designee will review abuse reporting procedures through the end of 2024.
In addition to the steps outlined above, the following will be implemented as well.
• In the incident cited above, the resident was assessed, evaluated at the hospital, evaluated by his PCP, and eventually was admitted to hospice services.
• Moving forward, all resident falls will be reviewed from the previous week at Weekly Clinical Meetings.
• Any residents with a greater than two falls will be deemed a High Fall Risk and the following will take effect:
o Evaluation for therapy, if appropriate
o Evaluation by PCP to determine underlying factors contributing to change
o Medication review
o Additional One Hour Checks will be implemented for the period of one week and then re evaluated for necessity

Licensee's Proposed Overall Completion Date: *01/18/2024*

Implemented ([redacted] - 01/29/2024)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 11/16/23 during the 11:00pm to 7:00am shift there were approximately 26 residents in the home and no staff members working on site that were certified in CPR.

On 11/25/23 during the 3:00p and 11:00pm there were approximately 26 residents in the home and no staff members working on site that were certified in CPR.

Plan of Correction ***Accept ([redacted] - 12/27/2023)***

• Immediately on 11/29/23, the RWD and ASD reviewed the schedule to ensure there was at least one staff person per shift to ensure compliance.
• During the On Boarding Process the EOO or ASD will obtain First Aid/CPR certifications for each Team Member that has the proper education requirements. All First Aid/CPR certifications that are obtained during the On Boarding Process will be placed the community's CPR/First Aid Training binder by the ASD or EOO.
• By 12/31/23, the ASD or EOO will audit all employee files to ensure that the appropriate number of staff persons are trained in First Aid/CPR to meet the regulatory requirement.
• Starting 11/29/23, routine audits of the employee schedule will be completed by the RWD or ASD to ensure

63a First Aid/CPR Training (continued)

regulatory compliance with staff on shift having First Aid/CPR certification.
• Beginning 11/29/23, routine weekly audits will take place weekly prior the schedule being posted by the ASD and RWD starting y beginning. The copy of the audited schedule, denoting associates who are CPR /First Aid certified, will be kept by the RWD. Schedules notating the CPR /First Aid certified associates will be kept through 12/31/2024.
• On 1/18/24 is the date of the next First Aid/CPR Class. Any and additional classes will be scheduled as necessary to meet compliance throughout the 2024 year.

Licensee's Proposed Overall Completion Date: *01/18/2024*

Implemented (- 02/05/2024)

82c - Locking Poisonous Materials

3. Requirements

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.

Description of Violation

On 11/28/23 at 11:01am a 100 Count Package of Washcloths were observed in Resident 3's bathroom. The Safety Data sheet for the McKesson Washcloths states "Ingestion and Inhalation: Seek Medical Attention Immediately." Resident 3's medical evaluation (DME) dated 6/29/23 and resident assessment and support plan (RASP) dated states that the resident is unable to safely use and avoid poisonous materials.

On at the following items were observed in Resident #4's bathroom:

- *100 Count Washcloths Safety Data sheet for the Washcloths states "Ingestion and Inhalation: Seek Medical Attention Immediately."*
- *8floz Perineal & Skin Cleaner Product label states "In case of eye irritation contact a physician.*
- *1.5oz Tube of Toothpaste*
- *1.0oz Tube of Protection Toothpaste.*

The product labels for the toothpaste states "if more than used for brushing is accidently swallowed get medical help or contact poison control." Per Resident 4's DME and RASP dated states the resident is unable to safely use and avoid poisonous materials.

On at the following items were observed in Resident #5's bathroom:

- *100 Count Washcloths Safety Data sheet for the Washcloths states "Ingestion and Inhalation: Seek Medical Attention Immediately."*
- *2.5oz Tube of Remedy Botanical Nutrition for Sensitive Skin Antifungal Ointment*
- *2 4floz Tubes of Skin Repair Cream.*

The Product labels for the Skin Care items each state "Keep out of reach of children. If swallowed, get medical help, or contact a Poison Control Center right away. Per Resident #5's DME dated and RASP dated states the resident is unable to safely use and avoid poisonous materials.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept (- 12/27/2023)***

• Immediately on 11/28/23, the items, identified above, were removed from the resident rooms, and relocated and stored in a secure location.
• By 12/27/23, a complete audit of all resident rooms will be conducted by the SME and RWD. All items found out of compliance will be secured in the community's spa rooms in the bins identified for each resident.
• By 12/31/23 a check for poisonous materials this will be added to the Weekly Housekeeping Room Cleaning Checklist.
• By 1/12/24, education to all staff will be complete.
• Starting 1/12/2024, the EOO, SME, and/or RWD will complete an audit of all resident rooms at least monthly to ensure regulatory compliance and will review results of the audit at the community's monthly QA/SQUIRT meeting.

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented - 02/05/2024)

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 11/28/23 at 10:27am, 3 10oz Bottles of Grey Poupon Mustard were observed in the pantry with an expiration date of 4/29/23.

On 11/28/23 at 10:29am, 1 Can of Campbells Cream of Mushroom Soup was observed with a small dent in the can.

Plan of Correction ***Accept - 12/27/2023)***

• Immediately on 11/28/23, the items, identified above, were removed from the kitchen and discarded.
• By 12/27/23, an audit of all stored food will be completed by the DED or EOO. All items found out of compliance will be discarded and replaced as needed.
• By 12/31/23 a check for Outdated Food will be added to the Weekly Order Guide to ensure no cans are dented or expired food items present.
• By 1/12/24, education to all staff will be complete.
• Starting 1/12/2024, DED or EOO will complete a monthly audit of all food items to ensure regulatory compliance and will review results of the audit at the community's monthly QA/SQUIRT meeting.

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/13/2024)

162c - Menus Posted

5. Requirements

162c - Menus Posted *(continued)*

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

On 11/29/23 at approximately 1:46pm, The home's menu for the week was posted in a conspicuous and public place. However, the menu for the following week was not posted.

Plan of Correction ***Accept (- 12/27/2023)***

• Immediately on 11/29/23, second week of the menu was posted.
• By 12/31/23 a check for two weeks' worth of menus will be added to the Daily Kitchen Checklist. This checklist will be completed daily by the dietary staff. The DED will ensure proper completion of checklists.
• By 1/12/24, education to all staff will be complete.
• Starting 1/12/2024, DED or EOO will audit the Daily Kitchen Checklists and review results at the community's monthly QA/SQUIRT meeting.

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/06/2024)

171b5 - First Aid Kit

6. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The Dodge Caravan used to transport residents did not include a first aid kit.

Plan of Correction ***Accept - 12/27/2023)***

• Immediately on 11/29/23, the first aid kit was returned to the van once sited.
• By 12/31/23 a weekly task will be added to TELS (the work order maintenance system) for the SME to ensure the van first aid kit is present within the vehicle.
• By 1/12/24, education to all staff will be complete regarding the need to have a first aid kit within the community vehicle.
• Starting 1/12/2024, SME or EOO will audit TELS First Aid Kit task and review results at the community's monthly QA/SQUIRT meeting.

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/05/2024)

185a - Implement Storage Procedures

7. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 11/29/23 at approximately 10:30am, Resident 6's Glucometer was cross-referenced with the Medication Administration Record (MAR) resulting in the following:

- *On [redacted], a Glucometer reading of [redacted] at [redacted] was not listed on the on the MAR.*
- *On [redacted], a Glucometer reading of [redacted] at [redacted] was not listed on the on the MAR.*
- *On [redacted], a Glucometer reading of [redacted] at 1[redacted] was not listed on the on the MAR.*
- *On [redacted], a Glucometer reading of [redacted] at [redacted] was not listed on the on the MAR.*
- *On [redacted], a MAR reading of [redacted] at [redacted] was listed in the Glucometer*
- *On [redacted] a Glucometer read [redacted] at [redacted], however the reading on the MAR read [redacted].*

Plan of Correction ***Accept ([redacted] - 12/27/2023)***

• Immediately on 11/29/23, staff began obtaining blood sugars for Resident 6 using only the resident's assigned glucometer and a finger stick.
• By 1/18/24, all Medication Associates will be educated on the following items:
o Readings from the machine will be documented into the MAR accurately with every finger stick.
o Sticky notes are on the cart. Document the reading right away on paper.
• Starting 12/26/23, all Glucometers readings will be compared to the MAR to ensure proper documentation.
• Audits will be completed weekly by the RWD, LPN Supervisor, or designee.
• By 1/18/24, education will be provided for all MAs and Nurses on proper use of the glucometer and accurate documentation on the MAR.

Licensee's Proposed Overall Completion Date: *01/18/2024*

Implemented [redacted] - 02/05/2024)