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

March 22, 2024

[redacted], MEMBER
MAGNOLIA PLACE MANAGEMENT LLC
[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 12/06/2023, 12/07/2023, 01/02/2024 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 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]

Certificate(s) of Occupancy

Type: *C-2 LP*	**Date**: *11/19/1997*	**Issued By**: *L&I*
Type: *C-2 LP*	**Date**: *08/29/1994*	**Issued By**: *L&I*
Type: *I-1*	**Date**: *12/14/2023*	**Issued By**: *Saxonburg Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *NaN* **Waking Staff**: *NaN*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *01/02/2024*

Inspection Dates and Department Representative

12/06/2023 - On-Site: [redacted]
12/07/2023 - On-Site:
01/02/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *lower level* **Capacity**: *32* **Residents Served**: *17*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *49*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

12/06/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/19/2024*

01/22/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/01/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/29/2024*

01/23/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/01/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/02/2024*

03/22/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/01/2024*

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

85d Trash Receptacles

1. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 12/6/23, at 11:53 a.m., there was an uncovered/open garbage bag half filled with refuse in the kitchen located on the garden's unit. The garbage bag was black and of the 40-gallon variety.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

- *On 12/06/23 facility maintenance director discarded garbage bag and placed a second trash receptacle in the kitchen to accommodate Styrofoam containers being utilized in response to a COVID-19 outbreak.*
- *Beginning 12/07/23 administrator will audit weekly for two months to ensure compliance. Documentation will be kept. Audits will be reviewed at monthly QA/QI meetings beginning January 2024.*
- *Current staff will be educated by administrator on regulation 2600.85(d) by 01/19/24.*

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 03/22/2024)

101j3 Bed/Linens/Pillows/Blankets

2. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 12/6/23, at 11:20 a.m., resident #1 had no fitted sheets on [redacted] bed.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

- *On 12/06/23 direct care staff applied a fitted sheet to the bed of resident #1.*
- *Beginning 12/07/23 administrator will audit beds throughout the facility on a weekly basis for two months to ensure compliance. Documentation will be kept. Audits will be reviewed at monthly QA/QI meetings beginning January 2024.*
- *Current staff will be educated by administrator on regulation 2600.101(j)(3) by 01/19/24.*

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 03/22/2024)

102g Individual Toiletry Items

3. Requirements

2600.
102.g. Individual toiletry items including toothpaste, toothbrush, shampoo, deodorant, comb and hairbrush shall be made available to residents who are not recipients of SSI. If the home charges for these items, the charges shall be indicated in the resident home contract. Availability of toiletry items for residents who are recipients of SSI is specified in § 2600.27(d)(1) (relating to SSI recipients).

102g - Individual Toiletry Items *(continued)*

Description of Violation

On 12/6/23, at 10:43 the common bathroom located next to the nurse station in the memory care unit had no toilet paper.

Plan of Correction ***Accept (- 01/22/2024)***

- *On 12/06/23 housekeeping staff replenished common bathroom toilet paper.*
- *Beginning 12/07/23 facility maintenance director and/or administrator will audit daily for two weeks then weekly for one month to ensure compliance. Housekeeping staff will audit daily thereafter. Documentation will be kept. Audits will be reviewed at monthly QA/QI meetings beginning January 2024.*
- *Current staff will be educated by administrator on regulation 2600.102(g) by 01/19/24.*

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented (- 03/22/2024)

123c - Evacuation Diagrams

5. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

On 12/6/23, at approximately 11:15 a.m., the fire safety diagram on the memory care unit indicated two sets of double fire safety doors present in the middle of the long hallway of the memory care unit. However, there are only one set of double fire safety doors present.

Plan of Correction ***Accept - 01/22/2024)***

- *On 12/08/23 administrator located correct diagram and redisplayed. Diagram was accessed by contractor/vendor during active remodel project and inadvertently placed within picture frame. Administrator provided verbal education to contractors/vendors.*
- *Beginning 12/08/23 administrator will check diagram weekly for two months to assurance compliance. Documentation will be maintained and reviewed at QA/QI meetings beginning January 2024.*
- *On 11/29/23 facility maintenance director obtained a quote from SignPro to obtain permanent SDCU fire safety diagrams secondary to remodel project. Upon remodel project completion new fire safety diagrams will be installed to permanently prevent reoccurrence.*

Licensee's Proposed Overall Completion Date: *02/08/2024*

Implemented - 03/22/2024)

131f - Fire Extinguisher Inspection

6. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

131f Fire Extinguisher Inspection *(continued)*

Description of Violation

On 12/6/23, at 10:35 a.m., the fire extinguisher next to the laundry room on the home's memory care unit had no attached documentation of an annual inspection conducted by a fire safety expert.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

- *On 09/26/23 all fire extinguishers at the community were inspected by Fire Fighter Sales and Service Co. In addition to annual and semi annual inspections, the maintenance director inspects every fire extinguisher monthly in accordance with the criteria established in the National Fire protection Association Standard 10, Portable Fire Extinguishers. On 12/06/23 during the physical plant inspection one fire extinguisher with a damaged tag was observed. The extinguisher was inspected and dated to meet the criteria of NFPA 10 to verify that the operating instructions on nameplates are legible and face outward; to check for broken or missing safety seals and tamper indicators; examine for obvious physical damage, corrosion, leakage, or clogged nozzle. In addition to marking the tags on individual fire extinguishers, the maintenance director keeps preventative maintenance records on file of the fire extinguisher monthly inspections. NFPA 10 Section 7.2.4.1.1 permits the record as a satisfactory alternative to tags on the extinguisher. Although that is the case, the facility uses the tags. Every other extinguisher in the community had an appropriate tag.*
- *On 01/12/24 all fire extinguishers were inspected by Fire Fighter Sales and Service. Damaged tag replaced by fire safety expert. Resealable fire extinguisher tag covers were ordered and will be used in the SDCU preventively. Facility maintenance director will apply tag covers upon receipt in addition to retaining one inspected fire extinguisher on stock as emergency replacement measure. Fire safety expert will be verbally notified by facility maintenance director if tags become damaged and request replacement.*

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented ([redacted] - 03/22/2024)

133.1 - Exit Signs

7. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

On 12/6/23, at approximately 11:00 a.m., the doorway in the rear of the memory care unit's dining room had signage indicating the egress as an exit, however, this point of egress was not an exit.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

- *On 12/07/23 facility maintenance director removed exit sign.*
- *On 12/07/23 facility maintenance director installed permanent signage indicating no exit to outside of building from this courtyard.*
- *Beginning January 2024 facility maintenance director will audit signage monthly for three months to assure regulatory compliance.*

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented [redacted] - 03/22/2024)

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribed [redacted] subcutaneously twice daily do not mix with other insulin. However, the medication's label indicates inject 5 units subcutaneously twice a day.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

- *On 12/06/23 a directions change label was applied to the original packaging for immediate correction.*
- *Resident services director and/or designee will complete entire house cart audit to measure compliance by 01/15/24.*
- *Current staff will be educated by resident services director and administrator on regulation 2600.184(a) by 01/19/24.*
- *Beginning 02/01/24 resident services director and/or designee will audit med carts monthly to ensure compliance. Documentation will be kept. Audits will be reviewed at monthly QA/QI meetings beginning January 2024.*

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 03/22/2024)

185a - Implement Storage Procedures

9. 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

Resident #2 is prescribed [redacted] the resident's medication administration record indicated a blood glucose level of 202. However, the resident's glucometer indicated a blood glucose level of [redacted] at the previously specified date and time.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

- *Current staff will be educated by resident services director and administrator on regulation 2600.185(a) by 01/19/24.*
- *Administrator, resident services director or support nurse will audit glucometers and medication administration records to measure compliance by 01/31/24.*
- *Resident services director or designee will audit weekly for one month beginning 02/01/24 then audit 25% of resident glucometers and medication administration records once a month for three months to ensure staff is accurately recording readings. Audits will be reviewed at monthly QA/QI meetings beginning January 2024.*

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented (- 03/22/2024)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident #2 is prescribed . On ., the resident had a blood glucose reading of however, the resident was administered unit of insulin.

Resident #3 is prescribed take one capsule orally daily. However, the resident was not administered this medication on 12/6/2023. The medication was not available in the home.

Plan of Correction ***Accept - 01/22/2024)***

- *Resident #2 administrator provided verbal education to nurse on 12/11/23. Administrator, resident services director or support nurse will audit glucometers and medication administration records to measure compliance by 01/31/24.*
- *Resident services director or designee will audit weekly for one month beginning 02/01/24 then audit 25% of resident glucometers and medication administration records once a month for three months to ensure compliance. Audits will be reviewed at monthly QA/QI meetings beginning January 2024.*
- *Resident #3 new prescription received 11/30/23 faxed to pharmacy for profile and fill. Pharmacy provided partial fill pending insurance authorization. Resident services director verbally notified pharmacy 12/04/23 two-day supply remained and requested medication delivery. Resident services director or support nurse will contact prescribing practitioner for alternative solution to prevent reoccurrence.*
- *Current staff will be educated by resident services director and administrator on regulation 2600.187(d) by 01/19/24.*

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented - 03/22/2024)