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

June 26, 2025

[redacted] CEO
FREDERICK MENNONITE COMMUNITY
2849 BIG ROAD - OFFICE
ZIEGLERVILLE, PA, 19492

RE: FREDERICK LIVING - MAGNOLIA HOUSE
2849 BIG ROAD
ZIEGLERVILLE, PA, 19492
LICENSE/COC#: 12772

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/26/2025, 02/27/2025, 02/28/2025 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: *FREDERICK LIVING - MAGNOLIA HOUSE* **License #:** *12772* **License Expiration:** *07/22/2025*

Address: *2849 BIG ROAD, ZIEGLERVILLE, PA 19492*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *FREDERICK MENNONITE COMMUNITY*

Address: *2849 BIG ROAD - OFFICE, ZIEGLERVILLE, PA, 19492*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/19/2000* **Issued By:** *COPA L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *67* **Waking Staff:** *50*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *02/28/2025*

Inspection Dates and Department Representative

02/26/2025 - On-Site: [redacted]
02/27/2025 - On-Site: [redacted]
02/28/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served:** *57*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *57*

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

Have Mobility Need: *10* **Have Physical Disability:** *0*

Inspections / Reviews

02/26/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/28/2025*

Inspections / Reviews *(continued)*

03/28/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/02/2025*

04/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/25/2025*

06/26/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2025*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 2/19/25 at 8:00 P.M., Resident # 1 reported to Staff Member A that Staff Member B held their hands down and pushed them into the bedroom. The home did not report this incident to the department until 2/21/25.

Plan of Correction ***Accept (- 04/02/2025)***

• The incident was reported to DHS once administrative staff were notified on 2/21/25
• Care staff were reeducated on reportable incidents-PCHA/Designee and list of reportable incidents was added to the bulletin board in the care base- 2/28/25
• Staff will discuss incidents during shift report, census report updated on 3/19/25.
• Nursing census report will be reviewed by PCHA/DON/Designee daily for two months to check for potential reportable incidents, beginning 4/2/2025.

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented (- 06/26/2025)

42c - Treatment of Residents

2. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 2/19/25 Staff member A observed Resident #1 in the main lobby with their lowered head resting in their hands. The resident reported being upset that Staff Member B would not assist with finding their glasses or using the cell phone. Staff Members A and C stated that they were unable to help Resident # 1 obtain access cell phone because it was locked with a code that was unknown to them. Staff Member C also stated "it may not be been a bad thing" [that the resident could not access the cell phone] because the resident previously called the police as a false alarm to get attention from . The home has a phone with an outside line that residents are able to use; however, neither Staff A nor C offered this to the resident.

Plan of Correction ***Accept (- 04/02/2025)***

• Staff member B was immediately suspended pending internal and DHS investigation 2/21/24
• Staff member B and C were reeducated and counseled 3/4/25
• All care staff will be reeducated on treating residents with dignity and respect on 4/1/25 and 4/14/25 by DON/designee.
• Two residents will be interviewed at random weekly for two months to ensure they are being treated with dignity and respect by staff - PCHA/Designee, began on 3/11/25.

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented (- 06/26/2025)

95 - Furniture and Equipment

3. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 12/23/24 the pump that operates the home's sprinkler system stopped working. The home received a quote the repairs on 1/15/25. The home did not agree to this quote until 2/7/25. The home was aware this part takes 6-10 weeks to arrive. The pump was not repaired as of 2/27/25.

Plan of Correction ***Directed ([redacted] - 04/02/2025)***

• The Director of Campus Operations no longer employed with FL.

• Incoming Director of Campus Operations will be educated on timeliness of reporting and resolving fire safety incidents. Executive Director/designee. Interim Director will be trained on timeliness of reporting and resolving fire safety incidents by 4/17/25 - Executive Director/Designee.

• Community continues to wait for part to repair pump. Expected install date is May 8, 2025.

- Moving forward, safety issues will be tracked by the Director of Campus Operations and shared with the campus Safety Committee monthly to expedite timely approvals for fire safety issues.

Proposed Overall Completion Date: 04/17/2025

Directed Plan of Correction:

Immediately, the administrator or designee shall conduct fire drills to a public thoroughfare at least twice per month until the sprinkler pump is repaired.

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall consult with a fire safety expert to determine the home's maximum safe evacuation time without the aid of the sprinkler system in writing. The administrator shall ensure that residents are evacuated within the newly determined safe evacuation time for every drill.

Directed Completion Date: *04/17/2025*

Implemented ([redacted] - 06/26/2025)

132c - Fire Drill Records

4. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 9/26/24 does not include the accurate number of residents who evacuated. The home had 54 residents in the home when the alarm sounded and 54 residents evacuated in this fire drill. The fire drill record indicates that 54 residents were present in the home when the alarm sounded and only 51 residents evacuated.

132c - Fire Drill Records (continued)

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

• Audit of fire drill log will be completed and if new reports are required, they will be obtained- Director of Campus Operations or designee- 4/17/25

• Contractors will be educated on how to complete head count in event some residents have to be evacuated to separate areas. Director of Campus Operations or designee- 4/17/25

• March 2025 and April 2025 fire drill reports will be audited for accuracy - Director of Campus Operations or designee 4/17/25

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented ([redacted] - 06/09/2025)

132h - Designated Meeting Place

5. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 9/26/24 at 11:27 P.M., 3 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. The home's report indicate that these residents quarantined in their room due to infection with COVID-19.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

• Nursing staff will be reeducated on requirements to evacuate all residents during fire drills PCHA/DON/designee 3/30/25

• Contractors will be educated on how to complete head count in event some residents have to be evacuated to separate areas. Director of Campus Operations or designee- 4/17/25

• March 2025 and April 2025 fire drill reports will be audited for accuracy - Director of Campus Operations or designee 4/17/25

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented ([redacted] - 06/09/2025)

132i - Testing Fire Alarm

6. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the fire drill conducted on 8/12/24, the fire alarm was not "activated and functional" according to the home's

132i - Testing Fire Alarm (continued)

records. The report states "The horn did not activate in the fire compartment or Magnolia West. The alarm did not activate in Magnolia East."

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

• All residents were evacuated to safe zones within allowable time frame 8/12/24
• Faulty systems were identified during the drill 8/12/24
• Work order was requested, and system were repaired 8/19/24
• A test was run to ensure all systems were functioning appropriately 8/22/24
- Process changed to run additional fire drill if issues are identified/resolved with alarm system. 4/17/24

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented ([redacted] - 06/09/2025)

183e - Storing Medications

7. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 2/27/25 Resident # 3's Tresiba, was unopened in the medication cart. According to the manufacturer's instructions, this medication is to be refrigerated at a temperature range of 36 to 46 degrees Fahrenheit until opened.

Repeat Violation: 3/4/24 et al

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

• Unopened insulin was stored in fridge DON 2/27/25
• Audit completed to ensure resident meds are properly stored. DON 2/27/25
• Staff education will be provided to med tech and nurses on proper medication storage. DON/designee 3/30/25
• Nurse supervisor or designee will audit all new prescription medication orders weekly for two months to ensure proper storage. Audit will begin 4/3/25.

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented ([redacted] - 06/26/2025)

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:
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for Resident # 1's fentanyl patch does not include the following:

184a - Resident's Meds Labeled (continued)

1. The name of the medication.
2. The date the prescription was issued.
3. The prescribed dosage and instructions for administration.
4. The name and title of the prescriber.

Plan of Correction ***Accept (- 04/02/2025)***

• Audit will be completed to ensure all prescribed medications have pharmacy labels DON/designee 2/28/25
• Community will update handbooks and medication policy to include proper labeling of medications. Resident Council updated on 4/14, information posted and emailed to POA list on 4/15.
• Nurse education will be completed on new medication policy for all prescription orders DON/designee by 4/17/25
• Nurse supervisor or designee will audit all new prescription medications orders weekly for two months to ensure pharmacy label is intact. Audits will begin on 4/3/25.

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented (- 06/09/2025)

184b - Labeling OTC/CAM

9. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 2/27/24 , a package of Nexium 24 belonging to Resident # 1 was in the medication cart and was not labeled with the resident's name.

On 2/27/24 , two packages of Nasal Saline Spray belonging to Resident # 3 was in the medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept (- 04/02/2025)***

• Resident medication was labeled immediately 2/27/25.
• Medication audit will be completed to ensure all meds are properly labeled/stored DON/Designee 2/28/25
• All new orders will be audited for proper label and storage by DON/Designee weekly for two months beginning 4/3/25.
• Staff education on proper labeling of medication DON/PCHA/Designee 3/30/25
- Medication labeling and handling will be brought to PC QAPI meeting quarterly for 12 months.

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented (- 06/26/2025)

185a - Implement Storage Procedures

10. 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 # 4 is prescribed an accucheck once daily every Monday and Thursday. On 2/24/25 at 8:00 A.M. Resident # 4 had a glucometer reading 158, however it was recorded on the medication administration log as 154.

185a - Implement Storage Procedures (continued)

Repeat Violation: 3/4/24 et al

Plan of Correction ***Accept (- 04/02/2025)***

• Transcription error was corrected 2/27/25
• Audit on glucometer transcription will be completed by DON/designee by 2/28/25
• Med Tech/ Resident caregiver observation/education will be completed DON/designee by 4/17/25, started on 3/25/25.
• Glucometer transcription will be audited by DON/Designee weekly for two months, starting on. 4/3/25.

Licensee's Proposed Overall Completion Date: *04/17/2025*

Implemented (- 06/26/2025)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
9. Administration times.

Description of Violation

Resident # 4 is prescribed the below listed medications:

- *Accucheck's once daily on Mondays and Thursdays*
- *Aspirin Low Dose 81 mg 1 tablet once daily*
- *Glyburide Oral Tablet by mouth twice daily*

These medications were administered to Resident #4's from 2/1/25 through 2/26/25, however, the medication administration record does not indicate the specific administration times for these medications, only as AM or PM. The home reports that medication is administered in four hour blocks in the mornings and afternoons.

Plan of Correction ***Directed (- 04/02/2025)***

•Community to update policy on medication record, which moves from 4-hour blocks to exact times by 4/17/25. Removal of 4-hour blocks from order entry will ensure ongoing compliance.
• Community will update handbooks and medication policy. Resident Council updated on 4/14, information posted and emailed to POA list on 4/15.

Proposed Overall Completion Date: 04/17/2025

Directed Plan of Correction:

Starting within 5 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit 10 medication records weekly for 4 weeks then monthly for 2 months to ensure specific administration times and/or specific time of administration within 1 hour before or 1 hour after the time indicated on the MAR is present and correct.

187a - Medication Record *(continued)*

Directed Completion Date: *04/17/2025*

Implemented ([redacted] - 06/09/2025)