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

August 11, 2025

[redacted] ADMINISTRATOR
MAGNOLIA LEXI, LLC
[redacted]

RE: MAGNOLIA PERSONAL CARE
CENTER-BUILDING II
68 LEXI STREET
MIFFLINTOWN, PA, 17059
LICENSE/COC#: 33873

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/25/2025, 06/26/2025 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: *MAGNOLIA PERSONAL CARE CENTER-BUILDING II* **License #**: *33873* **License Expiration**: *03/22/2026*

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**: *L&I*

Type: *C-2 LP* **Date**: *06/17/1991* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *31* **Waking Staff**: *23*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *06/26/2025*

Inspection Dates and Department Representative

06/25/2025 - On-Site: [redacted]

06/26/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *31* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *31* **Are 60 Years of Age or Older**: *31*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *4*

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

Inspections / Reviews

06/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/26/2025*

Inspections / Reviews *(continued)*

07/25/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/01/2025*

07/28/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/18/2025*

08/11/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 6/10/24, at approximately 3:00 AM, resident #1 was watching television in [redacted] shared room with resident #2. Resident #2 started yelling and swearing at resident #1. Resident #1 then hit Resident #2 in the right eye. As a result of the incident, resident #2 was sent to the emergency room and received 7 stitches on [redacted] face. However, an Act 13 form was not completed and sent the local Area Office on Aging.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

On 06/26/2025, the administration was educated by the inspectors during their on-site inspection on the correct incident reporting, including the requirement of the Act 13 form. Starting 7/25/25, the administration will review all incident reporting daily, utilizing the Regulatory Compliance Guide, to ensure all correct steps are followed going forward.

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented ([redacted] - 07/29/2025)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 6/25/25, at approximately 10:50 AM, the medication administration record binder for all residents residing in the home were unlocked, unattended, and accessible on top of the medication cart located outside of the service window of the kitchen.

On 6/25/25, at approximately 10:50 AM, the current resident assessment and support plans for all the residents in the home were unlocked, unattended and accessible in the medication cart located outside of the service window of the kitchen.

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

On 06/25/25, immediately upon observing the unlocked cart and binder, the Administrator reminded the medication staff responsible that the medication charts and records must be locked at all times when unattended. The administration will in-service all medication staff on 7/28/25 regarding the importance of record confidentiality. Starting 7/16/25, the administration will perform and document daily walk-throughs to ensure compliance.

17 - Record Confidentiality *(continued)*

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented (- 07/29/2025)

42b - Abuse

3. 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 6/10/24, at approximately 3:00 AM, resident #1 was watching television in shared room with resident #2. Resident #2 started yelling and swearing at resident #1. Resident #1 then hit Resident #2 in the right eye. As a result of the incident, resident #2 was sent to the emergency room and received 7 stitches on face.

Plan of Correction ***Accept (- 07/28/2025)***

On 6/10/2024, overnight staff were reminded that all tvs in shared rooms need to be turned off by 10pm. On 06/14/2024, resident #2 was moved to a different room. On resident #1 was discharged from the home. From 02/25/25-3/30/25 all staff were in-serviced on abuse and neglect via online training. On 6/26/2025, the administration was educated by the inspectors during the on-site inspection on abuse. Starting 08/01/25, the administration will perform a sample of resident interviews each month to ensure everyone feels safe in the home.

Proposed Overall Completion Date: 08/01/2025
Proposed Overall Completion Date: 08/11/2025

Licensee's Proposed Overall Completion Date: *08/15/2025*

Implemented (- 08/11/2025)

65a - FS Orientation 1st Day

4. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was did not receive orientation on the following topics:
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction ***Accept (- 07/25/2025)***

On 06/26/2025, the Administrator was educated about orientation training and documentation by inspectors during their on-site inspection. On 7/24/2025, the administration will perform and document an initial audit to ensure all

65a - FS Orientation 1st Day (continued)

current staff have the required 1st day trainings. On 07/01/2025, Staff Person A was re-oriented on fire extinguishers, smoke detectors, fire alarms, and the telephone use and notification of emergency services. On 7/01/2025, the Administrator documented the training on the orientation form. The Administrator will be sure to complete all required orientation documentation upon hire and will review all new-hire trainings at the end of the first day of work. Starting 7/01/2025, the Administrator and the Administrator designee will initial all orientation training to ensure completion.

Licensee's Proposed Overall Completion Date: *07/24/2025*

Implemented ([redacted] - 07/29/2025)

88a - Surfaces

5. 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

On 6/25/25, the dining room ceiling was cracked in several areas. Also, there was approximately 3-inch circumference of dirt surrounding the square vent on the dining room ceiling.

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

On 06/26/2025, the administration was educated by the inspectors during their on-site inspection on the importance of surfaces being clean and in good repair. On 06/26/25, the Administrator contacted a contractor to get a quote to fix the ceiling. On 7/16/25, the contractor completed the repair of the ceiling. Starting 7/16/2025, the administration will perform daily walk-throughs to ensure all surfaces are clean and in good repair.

Licensee's Proposed Overall Completion Date: *07/24/2025*

Implemented ([redacted] - 07/29/2025)

132e - Fire Drill Sleeping Hours

6. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 9/18/24 at 3:00 AM.

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

On 06/26/2025, the Administrator was educated by inspectors during their on-site inspection on fire drills during sleeping hours. On 6/30/2025, at 5:30 AM, the Administrator conducted a fire drill during sleeping hours. On 7/01/2025, the Administrator added notations to the fire drill log to ensure the two overnight fire drills are done, no more than 6 months apart. The overnight fire drill will be conducted again in September and March and September going forward. Starting 07/24/2025, the administration will review all fire drills monthly to ensure the sleep drills are completed in March and September.

Licensee's Proposed Overall Completion Date: *07/24/2025*

132e - Fire Drill Sleeping Hours *(continued)*

Implemented ([redacted] - 07/29/2025)

183b - Meds and Syringes Locked

7. 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 6/25/25, at approximately 10:50 AM, the home's medication cart was unlocked, unattended, and accessible in the dining room.

Repeated Violation - 6/3/24, et al

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

On 6/25/25, immediately upon observing the unlocked medication cart, the Administrator reminded the medication staff responsible that all medication carts must be locked at all times when unattended. On 7/28/25, the administration will in-service all medication staff regarding the importance of medication carts being locked when unattended. Starting 7/16/25, the administration will perform and document daily walk-throughs to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented ([redacted] - 07/29/2025)

185a - Implement Storage Procedures

8. 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, 6/7/25, at 7:00 AM, the blood sugar reading on resident #3's glucometer was 79. However, the blood sugar reading documented on the resident's medication administration record was 102.

On 6/15/25, at 7:00 AM, the blood sugar reading on resident #3's glucometer was 159. However, the blood sugar reading documented on the resident's medication administration record was 180.

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

Starting 07/24/2025, the administration will perform weekly glucometer readings for 6 weeks and then monthly after that to ensure compliance. The staff will be re-trained on proper glucometer recording on 07/28/2025 by the administration.

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented ([redacted] - 07/29/2025)

225a - Assessment 15 Days

9. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #7 was admitted to the home on [redacted] however, the resident's assessment was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

On 6/26/25, the administration was educated by the inspectors during their on-site inspection on assessment documentation. From 6/26/2025 through 7/10/2025, the administration performed and documented an audit of all RASPs to ensure all assessment dates are within the recommended time frame. Starting 7/24/25, the administration will perform an audit of a sample of RASPs monthly to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/24/2025*

Implemented ([redacted] - 07/29/2025)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

On 6/10/24, resident #1 hit resident #2 in the right eye, resulting in resident #2 getting stitches. Resident #1 was discharged from the home on [redacted] However, resident #1 most current assessment, dated [redacted] identified the resident as having no issues with aggression.

Plan of Correction ***Accept ([redacted] - 07/25/2025)***

On 6/26/25, the administration was educated by the inspectors during the on-site inspection on updating RASPs. From 6/26/2025 through 7/10/2025, the administration performed and documented an audit of all RASPs to ensure all assessments are up to date. Starting 7/24/25, the administration will perform an audit of a sample of RASPs monthly to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/24/2025*

Implemented ([redacted] - 07/29/2025)

251b - Record Entries Legible

11. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

On resident #3's Vitamin D2 medication administration record from 6/3 - 6/6/25, the staff initials of the staff who administered this medication on these days is crossed out by an "X". As a result, the staff initials on these days are not legible.

251b - Record Entries Legible *(continued)*

Plan of Correction ***Accept (- 07/25/2025)***

On 7/28/2025, medication staff will be in-serviced on correct medication documentation. Starting 6/27/2025, the administration will perform weekly med-cart audits, including MARS documention.

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented (- 07/29/2025)