



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: September 19, 2017

Ms. Joy Bodnar,
Chief Operating Officer
The Brethren Home Community, Inc.
Attn: Pamela Hensal, PC Administrator
2990 Carlisle Pike
New Oxford, Pennsylvania 17350

**RE: Cross Keys Village- The Brethren Home Community
Certificate #: 342870**

Dear Ms. Bodnar:

As a result of the Department of Human Services' licensing inspection on May 22, 2017 and August 30, 2017 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Brett Swanger".

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report: 34287 - 05/19/2017 - Springs, Israel
 PCH Name: CROSS KEYS VILLAGE THE BROTHERS HOME COMMUNITY

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

The home completed an assessment on Resident #1 on 8/5/16 that identified the resident as having minimal mobility needs, and no identified need for supervision. Following this assessment, Resident #1 incurred falls on 10/19/16, 11/9/16, 12/5/16, 12/25/16, 2/19/17, 2/28/17, 3/14/17, 3/19/17, and 3/20/17. During the period of 11/16/16 through 3/20/17 the resident received occupational and physical therapies in an attempt to address the resident's increased risk of falls and degrading mobility. After the fall that occurred on 2/28/17, the resident displayed an increased level of pain as evidenced by documentation in the home's "Interdisciplinary Notes" and "Medication Administration Record". Attempts to alleviate the resident's on-going pain included the administration of Tylenol, Tramadol, heat wraps, and physical therapy. The home failed to conduct a new assessment, subsequent to that of 8/5/16, to evaluate the increased risk of falls, the degrading ability to ambulate safely, the level of supervision needed, and increased level of pain; identify the supports necessary to address these issues; and determine the home's ability to meet the increased needs of the resident. The fall on 2/28/17 resulted in hospitalization whereupon Resident #1 was diagnosed with a right foot fracture and discharged to a Skilled Nursing Facility. The home neglected to adequately perform the duties necessary to identify and address the risks of harm presented by Resident #1, resulting in serious pain and injury to the resident.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Attachment

Page 2A and 2B

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page)	<i>Pam Hensel Administrator</i>
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Pam Hensel Administrator</i>	<i>7/28/17</i>

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/1/17
(Date)

The above plan of correction was approved by BHS
(Initials)

Plan of correction implementation status as of 9/18/17
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.42(b)

While Cross Keys Village – The Brethren Home Community (“TBHC”) submits this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction is no way constitutes an admission of the alleged violation.

The residents will not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

The facility will complete an audit of assessments for residents by the administrator/designee to identify and address reassessment needs by 8/31/17. The facility will conduct an audit of resident support plans to identify and address supplemental support service needs by the Resident Services Manager/designee by 8/31/17. Support plans will be updated as indicated.

Fall Prevention and Post Fall Intervention Program reviewed and revised by interdisciplinary team. Initiated 24 Hour Review and Follow-Up Form to be completed during clinical meetings where accident/incidents, 24 hours report, and clinical shift to shift report will be reviewed with the interdisciplinary team. RASP and support plans will be updated as indicated.

Scheduled assessment and support plan meetings with residents, families, and the interdisciplinary team members will continue with the Resident Service Manager tracking annual review and significant change dates to ensure compliance.

All personal care staff will be educated on §2600.42(b), assessments, accident witness statements, and fall prevention and post fall intervention program by Administrator by 8/31/17. All Licensed Staff and Med Techs in addition will be educated on Accident/Incident Form and 24 Hour Resident Review and Follow-Up.

Resident Services Manager will audit 10 charts a month for RASP completion timely for three months and then quarterly for three quarters. Resident Services Manager will audit 10 charts a month to identify and address supplemental support service needs for three months and then quarterly for three quarters. The Resident Services Manager/designee will report findings from audits to the Quality Assurance Committee for three months for further recommendations.

The Bureau of Human Services Licensing (“BHSL”) alleges that TBHC “neglected to adequately perform the duties necessary to identify and address the risks of harm presented by Resident #1, resulting in serious pain and injury to the resident.” TBHC, however, disagrees with BHSL’s determination as TBHC implemented interventions to address and prevent falls and provided appropriate care and services to address resident’s complaints of pain. After the resident’s fall on 11/9/16, the facility requested an order for a physical therapy evaluation to address the weakness in resident’s legs and the resident started receiving therapy services as of 11/16/16. (Attachment A). Subsequent to the resident’s fall on 12/5/16, the resident received training with respect to wheelchair management to increase [redacted] ability to safely maneuver [redacted] power wheelchair. (Attachment B). The resident also received training related to the use of a rollator while in [redacted] room instead of the power wheelchair to increase safety. It should

Pam Hensel 11/28/17

also be noted that resident had an MMSE completed on 12/7/16, and the resident scored a 27 out of 30 which would indicate that the resident was capable of making [REDACTED] needs known and there were no concerns regarding any cognitive impairments that would have been a contributing factor related to the falls. (Attachment C). On or about 2/8/17, the facility staff had concerns regarding resident's safety during toilet transfers and resident began to receive therapy services to assist resident with toilet transfers as well as training related to the use of grab bars to prevent falls. (Attachment D). After the resident's fall that occurred on 2/19/17, facility staff added non-slip strips to the floor in front of resident's bathroom as well as in front of the resident's toilet to prevent falls. (Attachment E). The resident, however, subsequently fell on 2/28/17, and the resident was referred to therapy to decrease complaints of pain and minimize falls. (Attachment F). The facility staff also provided the resident with Tylenol and heat wraps to alleviate pain, and when resident continued to complain of pain, the facility staff notified the physician who prescribed Tramadol. (Attachment G). Thus, the facility was continually assessing and addressing resident's pain despite the surveyor's allegations. Additionally, the resident continued to receive therapy services to address resident's falls until [REDACTED] transfer to the hospital on [REDACTED]/17. (Attachments F & H). In conclusion, the facility staff timely notified the physician of the resident's falls, the facility staff implemented appropriate interventions to ensure the health and safety of the resident and at no time was the resident neglected. As such, we respectfully request that the violation cited under §2600.42(b) be removed.

Pam Fensel 1/28/17

Violation Report: 34287 - 05/19/2017 - Springs, Israel
 PCH Name: CROSS KEYS VILLAGE THE BRETHERN HOME COMMUNITY

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:

- (1) Annually.
- (2) If the condition of the resident significantly changes prior to the annual assessment.
- (3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

The home completed an assessment on Resident #1 on 8/5/16 that identified the resident as having minimal mobility needs, and no identified need for supervision. Following this assessment, Resident #1 incurred falls on 10/19/16, 11/9/16, 12/5/16, 12/25/16, 2/19/17, 2/28/17, 3/14/17, 3/19/17, and 3/20/17. The home did not complete a reassessment of the resident in response to this significant change in the resident's ability.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Attachment

Page 3A

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Ramfensal*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Ramfensal Administrator* Date *9/28/17*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/1/17
 (Date)

The above plan of correction was approved by BAS
 (Initials)

Plan of correction implementation status as of 9/18/17
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.225(c)

While Cross Keys Village – The Brethren Home Community (TBHC) submits this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction is no way constitutes an admission of the alleged violation.

The facility will complete assessments: annually, if the condition of the resident significantly changes prior to the annual assessment, and at the request of the Department upon cause to believe that an update is required.

The facility will complete an audit of assessments for all current residents by the administrator/designee to identify and address reassessment needs by 8/31/17.

Fall Prevention and Post Fall Intervention Program reviewed and revised by interdisciplinary team. Initiated 24 Hour Review and Follow-Up Form to be completed during clinical meetings where accident/incidents, 24 hours report, and clinical shift to shift report will be reviewed with the interdisciplinary team. RASP will be updated as indicated.

Scheduled assessment and support plan meetings with residents, families, and the interdisciplinary team members will continue with the Resident Service Manager tracking annual review and significant change dates to ensure compliance.

All personal care staff will be educated on assessments, accident witness statements, and fall prevention and post fall intervention program by Administrator by 8/31/17. All Licensed Staff and Med Techs in addition will be educated on Accident/Incident Form and 24 Hour Resident Review and Follow-Up.

Resident Services Manager will audit 10 a month charts for assessment completion timely for three months and then quarterly for three quarters. The Resident Services Manager/designee will report findings from audits to the Quality Assurance Committee for three months for further recommendations.

Pam Hensele 7/28/17

Violation Report: 34287 - 05/19/2017 - Springs, Israel
 PCH Name: CROSS KEYS VILLAGE THE BRETHERN HOME COMMUNITY

1. REGULATION 55 Pa.Code §2600

2600.227(d) - Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.

2a. DESCRIPTION OF VIOLATION

During the period of 11/16/16 through 3/20/17, Resident#1 received occupational and physical therapies in an attempt to address the resident's increased risk of falls and degrading mobility. The home failed to update the Resident Support Plan, dated 8/5/16, to include these therapies.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Page 4A

Repeat Violation: No	Date(s) of Previous Violation(s):			
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Ram Hensel*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Ram Hensel Administrator* Date *8/23/17*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/1/17
 (Date)

The above plan of correction was approved by BAS
 (Initials)

Plan of correction implementation status as of 9/18/17
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.227 (d)

While Cross Keys Village – The Brethren Home Community (TBHC) submits this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction is no way constitutes an admission of the alleged violation.

The facility will document in the resident's support plan the medical, dental, vision, hearing, mental health, or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.

The facility will conduct an audit of resident support plans to identify and address supplemental support service needs by the Resident Services Manager/designee by 8/31/17. Support plans will be updated as indicated.

Initiated 24 Hour Review and Follow-Up Form to be completed during clinical meetings where accident/incidents, 24 hours report, and clinical shift to shift report will be reviewed with the interdisciplinary team. Support plans will be updated as indicated.

Administrator/ Resident Service Manager or designee will continue to meet weekly with therapy to review residents receiving therapy and potential referrals.

Resident Service Manager will track annual review and significant change dates to ensure compliance.

Personal care staff will be educated on implementation of the support plan by Administrator or designee by 8/31/17.

Resident Services Manager will audit 10 charts a month to identify and address supplemental support service needs for three months and then quarterly for three quarters. The Resident Services Manager/designee will report findings from audits to the Quality Assurance Committee for three months for further recommendations.

Rantfensal 7/28/17

Violation Report: 34287 - 08/30/2017 - Swanger, Brett
 PCH Name: CROSS KEYS VILLAGE THE BRETHERN HOME COMMUNITY

1. REGULATION 55 Pa.Code §2600

2600.231(c) - A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION

Resident #1 was admitted to the Secured Dementia Care Unit (SDCU) of the home on [REDACTED] 2017. The home did not complete a preadmission screening form for this admission to the SDCU.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Within 72 hours prior to admission to our SDCU, a preadmission screening will be completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form.

An audit of all SDCU charts will be conducted by the Administrator or designee to ensure the preadmission screening form is complete. Chart audit will be completed by 9/30/17.

Within 72 hours of admission, the Medical Records Specialist or designee will audit new charts for the required record content and document on the Record Content form. See attachment (A)

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Pam Hensal*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Pam Hensal* Date *9/14/17*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/16/17
 (Date)

The above plan of correction was approved by BSS
 (Initials)

Plan of correction implementation status as of 9/16/17
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 34287 - 08/30/2017 - Swanger, Brett
 PCH Name: CROSS KEYS VILLAGE THE BROTHERS HOME COMMUNITY

1. REGULATION 55 Pa.Code §2600

2600.234(a) - Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

2a. DESCRIPTION OF VIOLATION

Resident #1 was admitted to the Secured Dementia Care Unit (SDCU) of the home on [REDACTED] 2017. The home did not develop a support plan for Resident #1's admission into the SDCU until 6/14/2017.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Within 72 hours of the admission, or within 72 hours prior to a resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident's record.

An audit of all SDCU charts will be conducted by the Resident Services Manager or designee to identify and address the need for support plan development, implementation and documentation.

The audit will be completed by 10/14/17.

Scheduled support plan meetings with residents, families, and the interdisciplinary team members will continue. The Resident Services Manager or designee will track 72 hour development, implementation and documentation to ensure compliance.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Pam Hensel*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Pam Hensel*

Date *9/14/17*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/18/17
 (Date)

The above plan of correction was approved by BAS
 (Initials)

Plan of correction implementation status as of 9/18/17
 (Date)

- Fully Implemented
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- Partially Implemented - Inadequate Progress
- Not Implemented