



November 14, 2019

Ms. Joy Bodnar  
Chief Operating Officer  
The Brethren Home Community, Inc.  
**Attn: Joy Bodnar**  
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's Bureau of Human Services Licensing annual inspection on September 3 and 4, 2019 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to [https://www.surveymonkey.com/r/BHSL\\_Inspection](https://www.surveymonkey.com/r/BHSL_Inspection).

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock". The signature is fluid and cursive.

Kevin Hancock  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Violation Report

# Violation Report

## Facility Information

Name: *CROSS KEYS VILLAGE - THE BRETHERN HOME COMMUNITY*  
Address: *2990 CARLISLE PIKE,, NEW OXFORD, PA 17350*  
County: *ADAMS*

License Number: *34287*

Region: *CENTRAL*

## Administrator

Name: *Justin Lee*

Phone: *7176245286*

Email: *J.BODNAR@CROSSKEYSVILLAGE.ORG*

## Legal Entity

Name: *THE BRETHERN HOME COMMUNITY INC*  
Address: *2990 CARLISLE PIKE, ATTN JOY BODNAR, NEW OXFORD, PA, 17350*

## Certificate(s) of Occupancy

Type: *Other*

Date: *06/10/2015*

Issued By: *Oxford Township*

## Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *127*

Waking Staff: *95*

## Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal,Incident*

## Inspection Dates and Department Representative

*09/03/2019 - On-Site: Hope O'Pake, Laura Heemer*

*09/04/2019 - On-Site: Hope O'Pake, Laura Heemer*

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: *104*

Residents Served: *90*

### Secured Dementia Care Unit

In Home: *Yes*

Area: *SDCU*

Capacity: *18*

Residents Served: *14*

### Hospice

Current Residents: *1*

### Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *90*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *37*

Have Physical Disability: *0*

Rec'd  
9/25/19  
GE

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

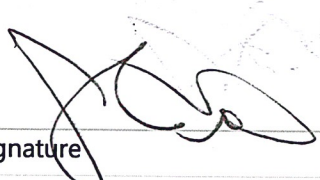
Direct Care Staff Persons A and B did not receive training in meeting the needs of the residents as described in the DME and RASP, or infection control, during training year 2018.

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.)

\*Please see attached pages for POC Page 2A of 4

Legal Entity Representative

Signature 

Justin M. Lee PCHA  
Printed Name and Title

9/25/19  
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

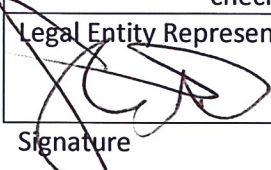
The above plan of correction is approved as of 10/21/19  
(Date)

Plan of correction implementation status as of 10/21/19  
(Date)

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

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

65f – Training Topics

<p><b>Regulations</b> 2600. 65.f. Training topics for the annual training for direct care staff persons shall include the following:</p>
<p><b>Description of Violation</b> Direct Care Staff Persons A and B did not receive training in meeting the needs of residents as described in the DME and RASP, or infection control, during training year 2018.</p>
<p><b>Plan of Correction (POC)</b> (Attach pages as necessary. Remember you must sign and date any attached pages. Including 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.) <i>Positions in Mission Point Personal Care (MPPC)</i> <b>PCHA – Personal Care Home Administrator</b> <b>DCS – Director of Clinical Services</b> <b>RSM – Resident Services Manager</b></p> <ol style="list-style-type: none"> <li>1. What specific change will be made?             <ol style="list-style-type: none"> <li>a. The Training Plan for 2019 includes all of the required education requirements as listed in 2600.65(f).</li> </ol> </li> <li>2. Who will make the change?             <ol style="list-style-type: none"> <li>a. The PCHA, the DCS, and the RSM ensured all required training topics are included in our 2019 training plan.</li> </ol> </li> <li>3. When will the change be made?             <ol style="list-style-type: none"> <li>a. A mandatory Skills Fair was conducted in June 2019 for all Direct Care Staff Team Members. During this training the team received education regarding the importance of meeting resident needs using the DME and RASP. They also received education on Infection Control during the Skills Fair.</li> </ol> </li> <li>4. How will the change be made?             <ol style="list-style-type: none"> <li>a. As described above, the training was conducted with Direct Care Staff in June of 2019. An additional training session will be completed by the end of October 2019.</li> </ol> </li> <li>5. What system have you implemented to make sure that the same violation will not occur again?             <ol style="list-style-type: none"> <li>a. The PCHA, DCS, and the RSM will ensure that the education requirements for all Direct Care Staff persons will be met through multiple educational offerings each calendar year. Staff training needs will be addressed during the home's periodic quality management reviews.</li> </ol> </li> <li>6. What training has been provided to the staff?             <ol style="list-style-type: none"> <li>a. Education has been provided to the team in 2019. Please attached copy of Skills Fair checklist that was used in June 2019.</li> </ol> </li> </ol>
<p>Legal Entity Representative</p> <div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="text-align: center;">               Signature         </div> <div style="text-align: center;"> <p>Justin Lee PCHA</p>             Printed Name and Title         </div> <div style="text-align: center;"> <p>9/25/19</p>             Date         </div> </div>

GE, 10/21/19

93a - Handrails

Regulations

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

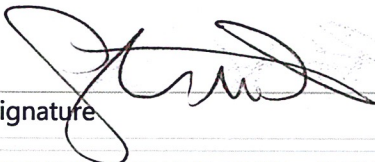
The landing outside of the emergency exit, leading from the stairwell to the outside near Resident Room 2920. has an approximate 4 inch drop from the landing to the ground level. There is no handrail present.

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.)

\*Please see attached pages for POC Page 3A of 4

Legal Entity Representative

Signature 

Justin M. Lee PCAA  
Printed Name and Title

9/25/19  
Date

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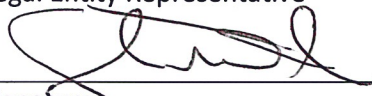
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93a – Handrails

<p><b>Regulations</b> 2600. 93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.</p>		
<p><b>Description of Violation</b> The landing outside of the emergency exit, leading from the stairwell to the outside near Resident Room 2920 has an approximate 4 inch drop from the landing to the ground level. There is no handrail present.</p>		
<p><b>Plan of Correction (POC)</b> (Attach pages as necessary. Remember you must sign and date any attached pages. Including 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.)</p> <ol style="list-style-type: none"> <li>1. What specific change will be made?             <ol style="list-style-type: none"> <li>a. A sidewalk was added to landing in September 2019 to eliminate the 4 inch drop. The sidewalk is level with the landing. See attached photos.</li> </ol> </li> <li>2. Who will make the change?             <ol style="list-style-type: none"> <li>a. A concrete company was contracted to add the sidewalk.</li> </ol> </li> <li>3. When will the change be made?             <ol style="list-style-type: none"> <li>a. September 2019</li> </ol> </li> <li>4. How will the change be made?             <ol style="list-style-type: none"> <li>a. A sidewalk has been added from the landing outside of the emergency exit and connected to an existing sidewalk for easier egress in the event of an emergency.</li> </ol> </li> <li>5. What system have you implemented to make sure that the same violation will not occur again?             <ol style="list-style-type: none"> <li>a. The Life Safety Supervisor inspected the grounds surrounding the Personal Care building and determined there were no other landings with significant drops to ground level.</li> <li>b. Annual inspections of landings and sidewalks will be conducted and Administrator will be notified of any concerns.</li> </ol> </li> <li>6. What training has been provided to the staff?             <ol style="list-style-type: none"> <li>a. The Maintenance Team was notified about the violation and a plan for annual inspection was established.</li> </ol> </li> </ol>		
<p>Legal Entity Representative</p>		
	<p style="font-family: cursive;">Justin M. Lee</p>	<p style="font-family: cursive;">9/25/19</p>
Signature	Printed Name and Title	Date

183b - Meds and Syringes Locked

**Regulations**

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**

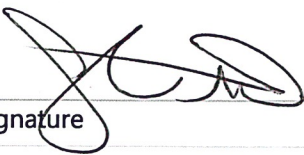
Resident Room 2953 in the SCDU was unlocked and a large bottle of Listerine Cool Mint Mouthwash was accessible to residents. This Bottle is labeled, "If ingested call Poison Control."

**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.)

\*Please see attached pages for POC Page 4A of 4

**Legal Entity Representative**

  
 Signature

Justin M. Lee PLHA  
 Printed Name and Title

9/25/19  
 Date

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183b – Meds and Syringes Locked

**Regulations**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area of container that is locked. This includes medications and syringes kept in the resident’s room.

**Description of Violation**

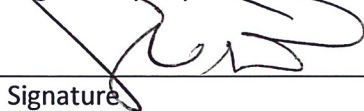
Resident Room 2953 in the SDCU was unlocked and a large bottle of Listerine Cool Mint Mouthwash was accessible to residents. This Bottle is labeled, “If ingested call Poison Control.”

**Plan of Correction (POC)**

(Attach pages as necessary. Remember you must sign and date any attached pages. Including 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.)

1. What specific change will be made?
  - a. The Listerine in the resident’s room in the SDCU was immediately removed upon discovery. Resident rooms in our SDCU will be checked by the Direct Care Staff daily to ensure that residents do not have access to potentially harmful substances.
2. Who will make the change?
  - a. Direct Care Staff will check resident rooms daily to ensure that there potentially hazardous substances are kept secured.
3. When will the change be made?
  - a. By October 31<sup>st</sup> 2019
4. How will the change be made?
  - a. The resident’s Responsible Party was contacted and educated about the need to keep potentially hazardous substances secured. The family was encouraged to seek staff guidance when bringing potentially harmful items to the room.
5. What system have you implemented to make sure that the same violation will not occur again?
  - a. Through daily rounds the Direct Care Staff will check to ensure that any potentially harmful substances are kept secure in each resident’s room.
6. What training has been provided to the staff?
  - a. Education about safety precautions for potentially harmful substances will be provided to all Direct Care Staff by the end of October 2019.

Legal Entity Representative



Signature

Justin M. Lee

Printed Name and Title

9/25/19

Date