

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

April 14, 2023

[REDACTED]  
SPIRITRUST LUTHERAN  
800 BOLLINGER DRIVE  
SHREWSBURY, PA, 17361

RE: SPIRITRUST LUTHERAN THE  
VILLAGE AT SHREWSBURY  
800 BOLLINGER DRIVE  
SHREWSBURY, PA, 17361  
LICENSE/COC#: 31027

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/30/2023 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: SPIRITRUST LUTHERAN THE VILLAGE AT SHREWSBURY License #: 31027 License Expiration: 06/17/2023  
 Address: 800 BOLLINGER DRIVE, SHREWSBURY, PA 17361  
 County: YORK Region: CENTRAL

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: SPIRITRUST LUTHERAN  
 Address: 800 BOLLINGER DRIVE, SHREWSBURY, PA, 17361  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 03/28/2001 Issued By: L&I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 64 Waking Staff: 48

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Incident Exit Conference Date: 03/30/2023

**Inspection Dates and Department Representative**

03/30/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 68 Residents Served: 57  
 Secured Dementia Care Unit  
 In Home: No Area: Capacity: Residents Served:  
 Hospice  
 Current Residents: 0  
 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: 7 Have Physical Disability: 3

**Inspections / Reviews**

03/30/2023 - Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/10/2023

04/07/2023 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 04/13/2023  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/13/2023

Inspections / Reviews (*continued*)

## 04/11/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/13/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/17/2023

## 04/14/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/13/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

## 42c - Treatment of Residents

## 1. Requirements

2600.

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

## Description of Violation

On [REDACTED] during the evening shift, staff person A made derogatory comments about resident #1 in front of resident #1.

On [REDACTED] during the evening shift, staff person A called resident #1 a derogatory name in front of resident #1.

On [REDACTED] during the evening shift, staff person B called resident #3 a derogatory name in front of other staff.

On [REDACTED] during the evening shift, staff persons A and B were speaking in a vulgar manner and making derogatory comments in front of residents #1 and #2.

## Plan of Correction

Accept (AC - 04/11/2023)

Staff members A and B and the LPN supervising both individuals at the time of the incident were suspended pending investigation on [REDACTED]. The PCHA and Health Services manager together suspended staff A. The Executive Director and PCHA suspended staff B. Initial reporting was completed by the PCHA to DHS and York Area Agency on Aging on [REDACTED]. Resident 1 was interviewed by the PCHA on [REDACTED] with [REDACTED] present and could not recall the incident and showed no signs of distress as a result of what [REDACTED] witnessed. Resident 2 was interviewed by the PCHA on [REDACTED] and [REDACTED] could not recall the incident and showed no signs of distress as a result of what [REDACTED] witnessed. Resident 3 was interviewed on [REDACTED] by the PCHA and reported that staff member B was "the best" and always treated [REDACTED] with kindness and respect. [REDACTED] did not have any knowledge of any comments that may have been made about [REDACTED]. Follow up interviews were completed by the Health Services Manager on [REDACTED] with any alert and oriented residents living in rooms close to where the incident occurred and brought no additional information to the investigation. It was determined through the internal investigation that no emotional distress or harm came to the residents as a result of the behaviors exhibited by the staff on the evening on [REDACTED]. Despite that, staff persons A and B conducted themselves in a manner not acceptable to the organization and both were terminated on [REDACTED]. The LPN supervising staff members A and B was also terminated on [REDACTED] because [REDACTED] witnessed the behavior and failed to take action to intervene on behalf of the residents and to report the incident per protocol. A follow up meeting was held with Resident 1's [REDACTED] with the PCHA and Health Services Manager to report the outcome of the investigation on [REDACTED]. It was understood by the PCHA that the Health Services Manager had contacted Resident 2's [REDACTED] on [REDACTED] but after initial POC was submitted it was discovered that a call had not been made. Resident 2's [REDACTED] was contacted by phone by the PCHA on 4/7/2023 to report the outcome of the investigation. A mandatory inservice for nursing staff covering abuse, resident care expectations and staff conduct expectations will be taught by [REDACTED], Clinical Excellence Nurse on 4/5/23 at 5:30pm. Those unable to attend the initial training will be given one week to attend a make up session.

Licensee's Proposed Overall Completion Date: 04/13/2023

Implemented (AC - 04/14/2023)