STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395108	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Keys Village-Brethren Home Community, The	Box 128, 2990 Carlisle Pk New Oxford, PA 17350

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to provide adequate supervision and implement interventions to prevent falls, which resulted in actual harm as evidenced by a fall resulting in a laceration requiring sutures for one of three residents reviewed (Resident 1).Findings include: Facility policy, titled Fall Risk Program, reviewed March 2026, read, in part, Objectives: to decrease the number of falls and to prevent injury to Residents. Procedure Responsibility 3. Individualized interventions identified to decrease falls will be placed on Resident Care Guide (RCG) to communicate to staff.5. The interdisciplinary team will review falls daily during clinicals and revise care plans as necessary to ensure interventions are in place to prevent reoccurrence. Facility policy, titled Fall Prevention & Post Fall Intervention Program, reviewed March 2026, read, in part, Objectives: 1. To reduce or eliminate the number of Resident falls. 2. To ensure that appropriate measures were and/or need to be implemented. 3. To obtain information related to why the fall had occurred. 4. To assist with the development of interventions to be used to prevent and /or decrease the number of falls where possible and minimize or prevent injury to Residents. Review of Resident 1's clinical record revealed diagnoses that included glioblastoma (aggressive primary malignant brain tumor) with craniotomy (removal of a section of skull) and seizures (sudden uncontrolled surge of electrical activity in the brain). Review of Resident 1's care plan revealed a focus area for, at risk for falls, with an intervention for, Resident may sit in reclining lift chair, unplugged, and operated by staff only. Start date April 23, 2026. Review of Resident 1's Resident Care Guide (the nurse aid reference for resident care) revealed TRANSFER/AMBULATION/FALL PREVENTION . Resident is safe to sit in recliner chair. Chair to be unplugged and operated by staff only. Further review of Resident 1's clinical record revealed that Resident 1 was admitted to the facility from home on April 22, 2026. Resident 1 sustained three falls from her recliner chair on May 15, 2026; and June 9 and 10, 2026. Review of the fall incident report, dated May 15, 2026, revealed that Resident 1 had an unwitnessed fall in her room at 5:21 PM. Further review of the report revealed that Resident 1 was found lying on the floor in front of her recliner and that the recliner was in an elevated position. The report further indicated that therapy would re-screen Resident 1 for recliner safety. Review of the form titled Recliner Lift Chair Screen revealed that therapy evaluated Resident 1 on May 18, 2026. The form indicated that Resident 1 could not safely operate the reclining lift chair on her own and that the chair was to be unplugged and operated by staff only. Review of the fall incident report, dated June 9, 2026, revealed that Resident 1 had an unwitnessed fall in her room at 8:40 PM. Review of witness statements attached to the incident report revealed that Resident 1 was sitting on the ground with her chair raised. Review of the fall incident report, dated June 10, 2026, revealed that Resident 1 had an unwitnessed fall with injury in her room at 4:00 PM. Review of the incident report questionnaire dated June 10, 2026, at 11:38 PM, completed by Employee 3, revealed Additional contributing factors: recliner was not unplugged. Review of a witness statement from Employee 4, dated June 10, 2026, indicated that Employee 4 went to Resident 1's room around 3:40 PM - 3:45 PM to administer medications and that Resident 1 was sitting in the recliner. Review of a witness statement from Employee 5 (CNA assigned (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	to Resident 1 at the time of the fall), dated June 10, 2026, indicated that she completed rounds at 2:30 PM and that Resident 1 was in the recliner. Witness statements did not note if staff observed the recliner chair to be plugged in. Review of progress notes revealed a nursing note that read, in part, Called to assess resident for unwitnessed fall on 06/10/2026 at 1600. Neurochecks initiated. Resident was observed Lying on the floor slightly to her left side in front of her recliner. Laceration to upper outer corner of the left eye brow. Bright red bleeding noted from area. Glasses laying on floor with the left arm broken off . Review of the post fall assessment, stated the following: Injury noted at this time: Laceration to outer corner of left eye brown and ecchymosis [bruise] to left side of nose. Treatment provided: Laceration cleansed with NSS [Normal saline solution] and steri strips applied. Further review of the post fall assessment, in the comments section, stated that the family initially wanted Resident to remain in the facility, but when they came to visit the Resident, they requested that Resident be sent to ER for eval and treatment. Review of Resident 1's hospital emergency room summary dated June 10, 2026, revealed that Resident 1 was evaluated after sustaining a fall with a head strike. Hospital records indicated that Resident 1's laceration was approximately 2 centimeters long and required five sutures. During an interview with the Nursing Home Administrator (NHA) on June 15, 2026, at 1:00 PM, the NHA confirmed that she would expect staff to follow a resident's care plan and follow proper care techniques to prevent accidents. The facility failed to follow the plan of care for the Resident's recliner chair to be unplugged. The chair was left plugged in and the Resident sustained a fall from the chair, resulting in a head laceration that required sutures. 201.14(a) Responsibility of licensee201.18(b)(1)(e)(1) Management.211.10(c)(d) Resident care policies.211.12(d)(1)(2)(5) Nursing services.