

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Cross Keys Village-Brethren Home Community, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40010</p> <p>Based on review of facility policy, observations, and interviews with staff, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of eighteen residents reviewed (Resident 42).</p> <p>Findings include:</p> <p>Review of the facility policy titled, Medication Administration, with a last reviewed and revised date of February 2025, revealed, in step a., Proceed to resident's room and open resident's EMAR (electronic medical administration record)- pull out resident's medication packs.</p> <p>Review of Resident 42's clinical record revealed diagnoses that included diabetes (when the body either doesn't produce enough insulin or can't use insulin properly) and anxiety disorder (a group of mental health conditions characterized by excessive fear or worry, interfering with daily life and causing distress).</p> <p>Observation of Resident 42 on March 12, 2025, at 8:00 AM revealed resident 28 sitting a wheelchair in the dining room waiting to be served breakfast. Employee 1 (Licensed Practical Nurse) prepared Resident 28's oral medication and insulin for administration. Employee 1 then approached Resident 28, gave Resident 28 their oral medications, and then lifted Resident 28's shirt and injected Resident 28's insulin into the left side of her abdomen.</p> <p>Review of Resident 42's care plan failed to reveal a focus area or intervention that Resident 28 preferred to receive her medication in the dining room or in common areas.</p> <p>During an interview on March 13, 2025, at 10:28 AM with the Director of Nursing, she revealed that Employee 1 should not have given the insulin in the dining room, and that Resident 42 did not have a care plan or preference to receive medication and insulin in the dining room or common areas.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>34631</p> <p>Based on document review and staff interview, it was determined that the facility failed to ensure each resident is informed periodically of items and services not covered under Medicare for one of three residents reviewed after their Medicare stay (Resident 6).</p> <p>Findings Include:</p> <p>A review of the Skilled Nursing Facility Beneficiary Notification Review form revealed Medicare services ended for Resident 6 on February 19, 2025.</p> <p>A continued review of documents provided by the facility revealed that Resident 6 was not provided with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) form to notify Resident 6 and/or her Representative of the cost of the facility's items and services no longer covered under Medicare.</p> <p>An interview with the Director of Nursing on March 11, 2025, at 1:46 PM, confirmed that the facility could not locate the SNF-ABN form and that Resident 6 should have been provided with the notice at the conclusion of her Medicare coverage.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37116</p> <p>Based on observation, facility policy review, and staff interview, it was determined that the facility failed to ensure that food was prepared and served under sanitary conditions in the main facility kitchen.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Uniform Dress Code, last revised January 2025, stated, Restrain all facial hair with beard net/restraint.</p> <p>Observation on March 10, 2025, at 10:54 AM revealed Employees 3 and 4 (Dietary Aides) working in and around the kitchen with uncovered beards.</p> <p>During an immediate interview with Employee 2 (Director of Dining Services) he stated that he would review the policy.</p> <p>During an interview with the Nursing Home Administrator on March 12, 2025, at 1:46 PM he agreed that Employees 3 and 4 should have been wearing beard nets. He also revealed that Employee 2 had rectified the situation.</p> <p>28 Pa. Code 211.6(f) Dietary services</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40010</p> <p>Based on observations, facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure staff implemented infection control policies to prevent the spread of infection by using proper hand hygiene techniques for one of one medication observations (South Mountain).</p> <p>Findings Include:</p> <p>Review of facility policy titled, Hand Hygiene, last reviewed and revised January 2025, revealed that staff should perform hand hygiene immediately before touching a resident, after touching a resident or the resident's immediate environment, and immediately after glove removal.</p> <p>Observation on March 12, 2025, at 8:00 AM, revealed Employee 1 (Licensed Practical Nurse) preparing Resident 42's medications. The medications included oral medications and injectable medication. Employee 1 then administered the medications to Resident 42 by feeding Resident 42 the oral tablets on a spoon, then applying gloves, cleaning Resident 42's abdomen with an alcohol pad, and injecting Resident 42's medication into Resident 42's abdomen. Employee 1 then returned to her medication cart and prepared oral medication, injectable medication, and topical medication for Resident 7. Employee 1 then went to Resident 7's room and fed Resident 7 the oral medications with a spoon. Employee 1 then applied gloves, cleaned Resident 7's abdomen with an alcohol pad, and injected Resident 7's injectable medication into Resident 7's abdomen. Employee 1 then applied Resident 7's topical pain relief gel to Resident 7's left shoulder using the same gloves that she was wearing to inject Resident 7's injectable medicine. Employee 1 then proceeded to her medication cart and moved it down the hall to Resident 18's room. Employee one then prepared Resident 18's medication for administration. These medications included oral medications, injectable medication, topical medication patches, and eye drops. Employee 1 then entered Resident 18's room and provided Resident 18 her oral medications on a spoon. Employee 1 then applied gloves and administered Resident 18's eye drops. Employee 1 then removed her gloves and applied a new pair. Then Employee 1 applied a pain relief patch to the back of Resident 18's neck. She then applied a pain relief patch to Resident 18's lower back. Employee 1 then removed her gloves and applied new gloves, cleaned Resident 18's abdomen with an alcohol pad, and administered Resident 18's injectable medication in Resident 18's abdomen. Employee 1 then returned to her medication cart. At no time during the medication administration observation did Employee 1 perform hand washing or use hand sanitizer.</p> <p>An interview with Employee 1 at the end of the medication administration observation revealed that Employee 1's medication cart was stocked with hand sanitizing gel.</p> <p>An interview of the Nursing Home Administrator on March 13, 2025, at 11:15 AM, revealed that Employee 1 should have washed her hands or used hand sanitizer, as appropriate, and staff reeducation had already begun.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		