

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926 1660 East Street Road KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0610 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey and a Civil Rights Compliance survey, completed on January 9, 2025, it was determined that Crosslands was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0610		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926 1660 East Street Road KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0610  SS=D	Continued from page 1  483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by:	F 0610	The Facility will conduct a review of all current residents in similar situations for which an Electronic Event Report was submitted to the Pennsylvania Department of Health during the period January 9, 2024 to January 9, 2025. The Neglect Screening Tool will be utilized to conduct this review by the Interdisciplinary Team to ensure there were no other instances that required further investigation to determine neglect. Review will be completed no later than 2/28/25. Findings of this audit will be shared with the Facility Quality Assurance Committee at the next quarterly meeting. All staff will be re-educated on Facility Policy and Procedure titled Resident Abuse/Neglect/Misappropriation of Property Prevention (12/23) no later than 2/21/25. The training referenced above will also include discussion of the procedures to follow where, in different situations than this, "neglect" is found, and the	Completion Date: <b>03/07/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0610  SS=D	Continued from page 2	F 0610	subsequent investigations and reporting that must accompany such a finding. A follow-up review of incident and resident 52's medical record was conducted on January 20 -23, 2025 by Administrator, Director of Nursing, Medical Director and members of the Interdisciplinary Team. A Preventative Abuse Incident Monitor will be conducted by NHA or designee to include: Missing Property, Skin Incidents of Unknown Origin and Events Reported to Department of Health involving Abuse, Neglect, Misappropriation. This monitor will include any similar situations involving Event Reports submitted reported to the Pennsylvania Department of Health in which the checklist was utilized. Findings will be reported at the Quarterly QA Committee Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0610  SS=D	Continued from page 3  Based upon review of facility policy and procedure, clinical records, and review of facility documentation, it was determined the facility failed to investigate an incident that occurred as a result of possible abuse/neglect for one of one resident reviewed (Resident 52).  Findings include:  Review of facility policy and procedure titled Resident Abuse/Neglect/Misappropriation of Property Prevention, revised December 2023, revealed "All reports of abuse, as well as any situation where abuse is suspected, must be reported immediately to the Charge Nurse, and the Director of Nursing or supervisor on duty at the time. An investigation will be initiated immediately."  Further review of the facility policy revealed "Neglect refers to failure through inattentiveness, carelessness or omission to provide timely, consistent, safe, adequate and appropriate services, treatment and care including but not limited to:	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0610  SS=D	Continued from page 4  nutrition, medication, therapies and activities of daily living."  Review of Resident 52's care plan for continence at the time of the fall revealed "Toileting program: check and change upon awake, before bed, before and after meals, at midnight, 3 a.m. and 6 a.m."  Review of Resident 52's progress notes dated December 28, 2024, at 11:30 a.m. revealed "Firbank East [FE] nurse heard a loud "thump" from lounge area, when FE nurse walked over to see what the noise was, FE nurse discovered [Resident 52] on the floor, laying on right side in front of Broda chair, laying parallel to TV stand. Resident stated "I don't feel good. I feel dizzy. Resident assessment: oriented to self at baseline, lethargic, difficulty opening eyes and following commands, PERRL [pupils equal and reactive to light], large hematoma to right forehead measuring approximately 6 centimeters [cm] x 6 cm, c/o [complaining of] buttock pain, c/o dizziness and upset stomach. Education completed with FE staff	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0610  SS=D	Continued from page 5  regarding toileting care plan. Injuries: right forehead hematoma, skin slightly abraded but no bleeding or drainage."  Further review of Resident 52's progress notes revealed Resident 52's power of attorney was notified, and it was agreed to send Resident 52 to an acute care facility to rule out a bleed in the head.  Review of Resident 52's progress notes dated December 28, 2024, at 9:58 p.m. revealed "spoke with ER [emergency room] nurse at [acute care facility]. Report received - EKG [electrocardiogram] stable; CT scan of head and neck completed; both scans were negative. Resident cleared to return to facility."  Review of Resident 52's progress notes dated December 29, 2024, at 1:33 a.m. revealed "Resident returned from [acute care facility] at 00:10 a.m. to room 816. Resident awake and alert, at baseline with mentation; resident denies pain; bruising to right temple and right outer orbital.	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0610  SS=D	Continued from page 6  Resident had CT scans at [acute care facility] of head without contrast and of cervical spine. Head CT showed no acute intercranial abnormality, CT to spine showed no acute fracture. Resident was assessed. Resident had smear of feces to bilateral buttocks on return and was cleaned and brief put in place."  Review of facility documentation revealed Resident 52 was seen earlier in the morning by an RN at the facility at the dining room table. Resident 52 was "scooching" towards the edge of the Broda chair and was repositioned at that time.  Further review of facility documentation revealed Resident 52 was seen approximately 30 minutes prior to the fall by two staff persons. At that time, Resident 52 was also attempting to move forward in the Broda chair. The two staff persons repositioned Resident 52 in the Broda chair.  Review of documentation revealed the cause of the fall was failure to follow Resident 52's toileting care	F 0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0610  SS=D	Continued from page 7  plan.  Interview with Licensed Employee E3 on January 9, 2025, at 11:37 a.m. revealed that when a resident's care plan is not followed, the facility re-educates facility staff on following the care plan and confirmed that staff was re-educated, however, no further investigation was conducted.  This interview further revealed that abuse/neglect was not considered and an investigation into abuse/neglect was not conducted.  28 Pa. Code 211.11(a)(d) Resident care plan  28 Pa. Code 211.12(a)(d)(5) Nursing services	F 0610		
F 0641  SS=D		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641  SS=D	Continued from page 8  483.20(g) Accuracy of Assessments  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  This REQUIREMENT is not met as evidenced by:	F 0641	Upon review of MDS assessment for Resident 58, discharge location was marked in error on Discharge MDS Assessment of Resident 58, correction was immediately made ("hospital to home") and resubmitted on January 9, 2025 while surveyor was onsite. RNAC will run "Discharge Register" from EMR on a monthly basis to conduct an audit of discharge MDS and death trackers to confirm accuracy of discharge location. Findings of audit will be included in monthly Quality Assurance Documentation Committee report and reported at quarterly Quality Assurance Committee meeting.	Completion Date: <b>02/21/2025</b> Status: <b>APPROVED</b> Date: <b>01/31/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641  SS=D	Continued from page 9  Based on a review of clinical records and staff interview, it was determined that the facility failed to ensure that assessments accurately reflected the resident's status for one of 24 residents reviewed (Resident 58).  Findings include:  Review of Resident 58's discharge MDS (Minimum Data Assessment - periodic assessment of resident needs) assessment dated December 5, 2024, Section A2105 Discharge Status, indicated that the resident was discharged to an acute hospital.  Review of Resident 58's clinical record including the discharge/transfer summary dated December 5, 2024, revealed that the resident was discharged home on that date.  During an interview with the RNAC , Employee E4, on January 9, 2025, at 11:50 a.m. confirmed that the resident was discharged home and that the MDS assessment was marked incorrectly.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641  SS=D	Continued from page 10  483.20 Resident Assessments Previously cited 12/28/23  28 Pa. Code 211.5(f) Clinical records Previously cited 12/28/23  28 Pa. Code 211.12(c) Nursing services  28 Pa. Code 211.12(d)(1)(5) Nursing services Previously cited 12/28/23	F 0641		
F 0656  SS=G		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926 1660 East Street Road KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=G	Continued from page 11  483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	In accordance with Facility Policy-Comprehensive Person-Centered Care Plan (#11.01), the Interdisciplinary Team will meet each resident's goals, based on a comprehensive assessment of the resident's physical, psychological, social and spiritual needs. In addition, in accordance with Facility Policy – Minimum Data Set (MDS) Completion (#11.02), residents residing in skilled nursing will be assessed by the Interdisciplinary Team upon admission, annually, quarterly and with significant change in condition. A review of Resident #52 indicated the facility completed assessments for reference periods 5-14-24 to 5-20-24 (Comprehensive Admission Assessment); 8-14-24 to 8-20-24 (Quarterly Assessment) and 11-13-24 to 11-29-24 (Quarterly Assessment). A comprehensive review of Resident #52 Care Plans was completed January 23, 2025 by the Interdisciplinary Team and found to be current. All resident care plans are reviewed annually, quarterly and	Completion Date: <b>03/07/2025</b> Status: <b>APPROVED</b> Date: <b>02/18/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=G	Continued from page 12  discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.  This REQUIREMENT is not met as evidenced by:	F 0656	with significant change in condition. In accordance with the Facility Policy 5.13 – Resident Info SNAP Sheet, the Facility will conduct an audit using the Care Plan Audit Form of all current resident Care Plans, covering Activities of Daily Living, Continenence and Falls Prevention Care Plans to ensure Care Plans are current no later than March 7, 2025. Findings will be reported at the next quarterly Quality Assurance Committee meeting. Utilizing a Care Plan Monitoring Tool, beginning February 17th, 2025, a Facility staff member/designee shall monitor 10% of current residents weekly for the first four weeks to ensure care plans of current residents are being followed. Thereafter, monitoring of 10% of current residents will occur on a monthly basis up to 90 days. Findings will be reported at the next quarterly Quality Assurance Committee meeting. All staff will be educated on the definition, importance, and process for the comprehensive plan of care of residents no later than 2/21/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=G	Continued from page 13  Based upon review of clinical records, review of facility documentation, and staff interview it was determined the facility failed to follow a resident's care plan resulting in fall with subsequent actual harm of a hematoma requiring transportation to the Emergency Room for evaluation and treatment of a hematoma for one of three residents reviewed (Resident 52).  Findings include:  Review of Resident 52's care plan for continence at the time of the fall revealed "Toileting program: check and change upon awake, before bed, before and after meals, at midnight, 3 a.m. and 6 a.m."  Review of Resident 52's progress notes dated December 28, 2024, at 11:30 a.m. revealed "Firbank East [FE] nurse heard a loud "thump" from lounge area, when FE nurse walked over to see what the noise was, FE nurse discovered [Resident 52] on the floor, laying on right side in front of Broda chair, laying parallel to TV stand. Resident	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=G	Continued from page 14  stated "I don't feel good. I feel dizzy. Resident assessment: oriented to self at baseline, lethargic, difficulty opening eyes and following commands, PERRL [pupils equal and reactive to light], large hematoma to right forehead measuring approximately 6 centimeters [cm] x 6 cm, c/o [complaining of] buttock pain, c/o dizziness and upset stomach. Education completed with FE staff regarding toileting care plan. Injuries: right forehead hematoma, skin slightly abraded but no bleeding or drainage."  Further review of Resident 52's progress notes revealed Resident 52's power of attorney was notified, and it was agreed to send Resident 52 to the Emergency Room to rule out a bleed in the head.  Review of Resident 52's progress notes dated December 28, 2024, at 9:58 p.m. revealed "spoke with ER [emergency room] nurse at [acute care facility]. Report received - EKG [electrocardiogram] stable; CT (computed	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=G	Continued from page 15  tomography -medical imaging test that combines X-ray technology with computer processing to create detailed cross-sectional images of the body) scan of head and neck completed; both scans were negative. Resident cleared to return to facility."  Review of Resident 52's progress notes dated December 29, 2024, at 1:33 a.m. revealed "Resident returned from [Emergency Room of local hospital] at 00:10 a.m. to room 816. Resident awake and alert, at baseline with mentation; resident denies pain; bruising to right temple and right outer orbital. Resident had CT scans at [acute care facility] of head without contrast and of cervical spine. Head CT showed no acute intercranial abnormality, CT to spine showed no acute fracture. Resident was assessed. Resident had smear of feces to bilateral buttocks on return and was cleaned and brief put in place."  Review of Resident 52's care plan for continence at the time of the fall revealed "Toileting program: check and change upon awake, before bed, before	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>  STATE LICENSE NUMBER: <b>551202</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=G	Continued from page 16  and after meals, at midnight, 3 a.m. and 6 a.m."  Review of facility documentation revealed Resident 52 was seen earlier in the morning by an RN (Registered Nurse) at the facility at the dining room table. Resident 52 was "scooching" towards the edge of the Broda chair and was repositioned at that time.  Further review of facility documentation revealed Resident 52 was seen approximately 30 minutes prior to the fall by two staff members. At that time, Resident 52 was also attempting to move forward in the Broda chair. The two staff members repositioned Resident 52 in the Broda chair.  Review of facility investigative documentation revealed in section titled "Post Fall Investigation" revealed , "Last time toileted (approximately): 0900 (9:00 a.m)." Further review of same document revealed enquiry of Continent at time of fall: 'unknown -res (resident) transferred to ER, per FE nurse, resident did "feel wet."	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395388</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>CROSSLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>PO BOX 100 RT 926</b> <b>1660 East Street Road</b> <b>KENNETT SQUARE, PA 19348</b>		
STATE LICENSE NUMBER: <b>551202</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0656  SS=G	Continued from page 17  Additional review of the facility investigative documentation revealed the toileting care plan was not followed and the root cause of the fall was failure to follow Resident 52's toileting care plan.  Interview with Licensed Employee E3 on January 9, 2025, at 11:37 a.m. revealed that Resident 52's care plan was not followed and the facility re-educated facility staff on following the care plan.  The facility failed to follow Resident 52's toileting care plan, resulting in a fall which required transfer to Emergency Room for evaluation, testing, and possible treatment due to a large hematoma to Resident 52's face causing actual harm to Resident 52.  28 Pa. Code 211.12(d)(5) Nursing services	F 0656		



# Certified End Page

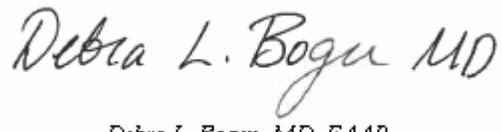
## CROSSLANDS

STATE LICENSE NUMBER: 551202

SURVEY EXIT DATE: 01/09/2025

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



Pennsylvania  
Department of Health

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY