STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER: Inners Creek Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 West Queen Street, Dallastown, PA 17313	

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility contract review, clinical record review, and staff interviews, it was determined that the facility failed to ensure the radiological diagnostic studies were done in a timely manner consistent with physician's orders for two of three residents reviewed (Residents 1 and 2). Findings include: Review of facility contract with their selected radiology provider dated January 1, 2023, revealed A stat service is provided for critical situations requiring rapid results, and 'STAT' orders shall be honored by Provider only when requested by the physician or non-physician practitioner. Customer [the facility] shall use its best efforts to limit 'STAT' orders to urgent situations where the absence of such an order could reasonably be believed to place the Patient's health in serious jeopardy or resulting serious bodily impairment or dysfunction. Review of Resident 1's clinical record revealed that they were admitted to the facility on [DATE], with diagnoses that included surgical repair of a displaced intertrochanteric fracture (a specific type of hip fracture in which the fracture occurs between the bony protrusions on the femur [thighbone] where the muscles of the thigh and hip attach) and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 1's clinical record progress notes revealed a note dated October 26, 2024, at 12:30 AM, that indicated that Resident 1 thought their hip was broken again. The note indicated that the nurse noted no rotation of the Resident 1's right leg, but Resident 1 said they could not move the leg. The note further indicated that the on-call practitioner was called and updated about this Resident and an order was received to do a stat (with no delay) x-ray. Review of Resident 1's clinical record revealed a radiology report dated October 26, 2024, which indicated Examination Date: 10/26/2024 11:06, which was 10 hours and 36 minutes after the original stat order was given, and Reported Date: 10/26/2024 11:35. The x-ray determined that there was satisfactory alignment of the fixating hardware and bony structures of the right hip and that there was no acute fracture. (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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's clinical record revealed they were admitted to the facility on [DATE], with diagnoses that included Alzheimer's Disease (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder, and unspecified abnormalities of gait and mobility. Review of Resident 2's clinical record progress notes revealed a note dated November 8, 2024, at 7:50 PM, that indicated Resident 2 was observed lying on the floor at the nursing station next to their wheelchair. The note also indicated that Resident 2 was very combative and swinging at staff, and was witnessed losing their balance and falling on the floor. The note further revealed that Resident 2 was complaining of pain to their right hip and that the on-call physician was called, and an order was given for x-rays of right hip and pelvic area. Review of Resident 2's facility provided incident report dated November 8, 2024, at 5:30 PM, revealed that Resident 2 was also noted on assessment by the nurse to have right leg extension at the time of the fall as well as the pain. The incident report further indicated that the on-call physician was notified of the fall at 5:50 PM. Review of Resident 2's physician orders revealed that the order for the x-rays of the right hip and pelvic areas was entered as a stat order. Review of Resident 2's clinical record revealed a radiology report dated November 8, 2024, which indicated Examination Date: 11/08/2024 22:42 [10:42 PM] which was four hours and 52 minutes after the original stat order was given, and Reported Date: 11/08/2024 23:02 [11:02 PM]. The x-ray determined that there was a displaced intertrochanteric fracture (a specific type of hip fracture in which the fracture occurs between the bony protrusions on the femur [thighbone] where the muscles of the thigh and hip attach) of the right femur. During a staff interview with the Director of Nursing (DON) on November 19, 2024, at 1:23 PM, the DON indicated that she was unsure of what the facility's radiology provider's contract said regarding time frame for obtaining stat x-rays, but in her experience, she would typically expect them to be done within 1-2 hours. The DON indicated that the nurse used her nursing judgment in requesting orders for x-rays for Resident 2 rather than sending Resident 2 to the hospital based on the assessment findings. She also indicated that Resident 2 had no other complaints of pain after the time of the actual fall. The DON later indicated in the same interview that, although there were long time lapses, she felt radiology services were appropriately provided for Resident 1 and 2. During a staff interview with the Nursing Home Administrator (NHA) on November 20, 2024, at 10:48 AM, the NHA indicated that he would expect stat x-rays to be obtained as soon as feasibly possible by the radiology provider. He indicated that turnaround time depends on the time of the day that stat x-rays are ordered as those tests ordered during normal business hours would be completed faster than those ordered outside normal business hours. He further indicated that once orders for x-rays are entered with the radiology provider, facility staff just wait for the tests to be completed as ordered. When asked if would have expected Residents 1 and 2 to have their x-rays completed sooner than the aforementioned timeframes, he indicated that it all depends on one's interpretation of timely. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management (continued on next page)

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	395451	A. Building B. Wing	11/20/2024

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy and procedures reviews, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the physician was promptly notified of abnormal x-ray results for one of three residents reviewed (Resident 2). Findings include: Review of facility policy, titled 5.8 Physician Notification, dated December 1, 2006, indicated, in part, 3. If resident's condition indicates urgent physician notification; 3.1 Notify physician immediately; 3.1.2 Report all pertinent data. Review of facility policy, titled NSG115 Physician/Advanced Practice Provider (APP) Notification, with a last revised date of December 1, 2021, revealed Upon identification of a patient who has a change in condition, abnormal laboratory values, or abnormal diagnostics, a licensed nurse will report to physician/advanced practice provider (APP). Review of facility provided document, titled After Hour, Weekend and Holiday Calls to Physicians/Advanced Practice Provider Process Guidelines, dated May 30, 2018, indicated: 1. If laboratory and/or diagnostic results are received between the hours of 5 pm and 7am, weekends and holidays, the licensed nurse will refer to the Interact File Cards and How to Report Laboratory Data to the On-Call Practitioner to determine if results require immediate or non-immediate reporting; b. If the determination is determined to immediate the licensed nurse will notify the Supervisor and the Supervisor will coordinate the call to the provider. Review of facility provided document, titled How to Report Laboratory Results to On-Call Physicians/ Advanced Practice Providers, dated May 6, 2018, indicated, in part, 3. Be prepared to provide the following information when reporting specific results. Stat -call the provider immediately. Review of Resident 2's clinical record revealed they were admitted to the facility on [DATE], with diagnoses that included Alzheimer's Disease (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and unspecified abnormalities of gait and mobility. Review of Resident 2's clinical record progress notes revealed a note dated November 8, 2024, at 7:50 PM, that indicated Resident 2 was observed lying on the floor at the nursing station next to their wheelchair. The note also indicated that Resident 2 was very combative and swinging at staff, and was witnessed losing their balance and falling on the floor. The note further revealed that Resident 2 was complaining of pain to their right hip and that the on-call physician was called, and an order was given for x-rays of the right hip and pelvic area. (continued on next page)

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's facility provided incident report dated November 8, 2024, at 5:30 PM, revealed that Resident 2 was also noted on assessment by the nurse to have right leg extension at the time of the fall as well as the pain. The incident report further indicated that the on-call physician was notified of the fall at 5:50 PM. Review of Resident 2's physician orders revealed that the order for the x-rays of the right hip and pelvic area was entered as a stat order. Review of Resident 2's November medication administration record revealed that they received a dose of Tylenol for pain at 5:10 PM, that was recorded as effective. There were no other entries indicating that Resident 2 required or received additional pain medication. Review of Resident 2's clinical record revealed a radiology report dated November 8, 2024, which indicated Examination Date: 11/08/2024 22:42 [10:42 PM] which was 4 hours and 52 minutes after the original stat order was given, and Reported Date: 11/08/2024 23:02 [11:02 PM]. The x-ray determined that there was a displaced intertrochanteric fracture of the right femur. Review of Resident 2's progress notes revealed a note dated November 9, 2024, at 6:46 AM, that indicated Resident 2's X-ray results showed a right primal femur fracture, that their Representative and the Director of Nursing were made aware, and that Resident 2 did ok through the night. The note failed to reveal that Resident 2's physician was notified of the fracture at this time. Further review of Resident 2's progress notes revealed a note dated November 9, 2024, at 10:04 AM, that indicated On call for Lumina left a message regarding femur fracture and that resident was being transported to [hospital] at 10:00 AM due to a 30 day contract. During a staff interview with the Director of Nursing (DON) on November 19, 2024, at 1:23 PM, the DON confirmed that Resident 2's physician was not made aware of the abnormal x-ray results until approximately 10:00 AM. The DON indicated that the nurse had texted her to inform her of the positive x-ray results and that after she reviewed the text, she informed the nurse that they needed to notify the physician of the results. The DON also confirmed that the Supervisor should have notified Resident 2's physician at the time the abnormal results were received. The DON indicated that Resident 2 had no issues throughout the night and had a planned transfer back to the hospital at 10:00 AM secondary to a contractual agreement with the hospital at the time Resident 2 was admitted to the facility. When asked about the time lapse in the reported time indicated on the actual x-ray report (November 8, 2024, at 11:02 PM) and the time the nurse documented that the results were received (November 9, 2024, at 6:46 AM) a span of 7 hours and 44 minutes, the DON indicated that she was not sure what the reported time on the actual report referred to. She indicated that she did not know if that was when the radiologist would have read the x-ray or when the report was released to the facility. During a staff interview with the DON and Employee 1 (Registered Nurse Unit Manager) on November 19, 2024, at 1:39 PM, Employee 1 indicated that the radiology provider does not usually call the facility to report negative findings. Employee 1 indicated that they just watch the portal in the electronic health record when they know a result is pending. During a staff interview with the DON on November 19, 2024, at 2:33 PM, she confirmed that she had no additional information to provide regarding the receiving of the x-ray results or physician notification for Resident 2. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview with the Nursing Home Administrator (NHA) on November 20, 2024, at 10:48 AM, the NHA indicated that Resident 2 was kept comfortable and remained calm at the facility while x-ray results were pending, and that Resident 2 was transported to the hospital at the prearranged time as part of another arrangement. He indicated that it depends on one's interpretation of timely as to whether the physician was notified appropriately. The NHA confirmed that Resident 2's physician was not made aware of the abnormal x-ray results until at least a minimum of 3 hours and 28 minutes after the nurse documented they received the results. He further indicated that notification of the physician at the time the results were received would not have changed the outcome for Resident 2. The NHA acknowledged that this statement could not be specifically confirmed since the physician was not provided the results until the time that Resident 2 was in the process of being transferred from the facility based on the prior contractual agreement. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services