STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395451	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inners Creek Skilled Nursing and Rehabilitation Ce	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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34631 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the physician reviews the resident's total program of care, including medications, for one of three residents reviewed (Resident 1). Findings Include: A review of Resident 1's clinical record revealed diagnoses that included bilateral knee osteoarthritis (a degenerative joint disease that causes the cartilage and bone in your joints to break down over time. It's the most common type of arthritis and can affect the hands, hips, knees, back, and other joints) and muscle weakness. A review of Resident 1's consultation form dated November 13, 2024, with an Orthopaedic Surgery Specialist ([NAME]), revealed recommendations that included a new order for Tylenol 1000 mg (milligrams) Q (every) 8 hours. A review of Resident 1's physician's orders revealed the Resident was already receiving Tylenol with an order that read Tylenol 8-hour oral tablet extended release three times a day for pain. Do not exceed [more than] 3 grams /24 hour. The order was dated October 15, 2024, and was 650 mg per day. An interview with Employee 1 (Registered Nurse) on December 23, 2024, at 9:59 AM, revealed she entered the new order for the 1000 mg of Tylenol for Resident 1 as the facility's Certified Nurse Practitioner (CRNP-Employee 2) signed off on the [NAME] consult and did not realize Resident 1 already had an order for the Tylenol 8 hour three times per day. Employee 2 is the provider working on behalf and in coordination with the Resident's attending physician. According to Employee 1, the Resident received over 15000 mg of Tylenol over three days, October 15-18, 2024. An interview with Employee 2 on December 23, 2024, at 10:51 AM, revealed the Resident should not have received more than 3000 mg per day due to concerns with liver damage. (continued on next page)

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

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Nursing Home Administrator on December 23, 2024, at 10:11 AM, revealed Resident 1 was placed on alert charting for five days, vital signs were monitored for five days, and blood testing was performed once for two weeks. An additional interview with Employee 2, at approximately 11:00 AM, revealed no concerns with a review of Resident 1's laboratory testing and no concerns with a change in the Resident's condition based on the excessive amount of Tylenol administered by the Nursing Staff. 28 Pa. Code 201. 18 (b) (1) Management 28 Pa. Code 211.12 (c) (d) (1) (2) (5) Nursing services

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34631 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing services to assure resident safety or maintain the highest practicable physical well-being of each resident for one of three residents reviewed (Resident 1). Findings Include: A review of the facility's Registered Nurse Job Description, revised June 16, 2017, read, in part, The Registered Nurse [RN] delivers efficient and effective nursing care while achieving positive clinical outcomes and patient/family satisfaction. He/she operates within the scope of practice defined by the State Nurse Practice Act . The RN manages patient care by performing nursing assessments and collaborating with the nursing team and other disciplines .to develop effective plans of care. A review of the facility's policy, titled Medication Administration, dated January 2024, read, in part, Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or the medication order seems unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to administration of the medication. A review of Resident 1's clinical record revealed diagnoses that included bilateral knee osteoarthritis (a degenerative joint disease that causes the cartilage and bone in your joints to break down over time. It's the most common type of arthritis and can affect the hands, hips, knees, back, and other joints) and muscle weakness. A review of Resident 1's consultation form dated November 13, 2024, with an Orthopaedic Surgery Specialist ([NAME]), revealed recommendations that included a new order for Tylenol 1000 mg (milligrams) Q (every) 8 hours. A review of Resident 1's physician's orders revealed the Resident was already receiving Tylenol with an order that read Tylenol 8-hour oral tablet extended release three times a day for pain. Do not exceed [more than] 3 grams /24 hour. The order was dated October 15, 2024, and was 650 mg per day. An interview with Employee 1 (Registered Nurse) on December 23, 2024, at 9:59 AM, revealed she entered the new order for the 1000 mg of Tylenol for Resident 1 as the facility's Certified Nurse Practitioner (CRNP-Employee 2) signed off on the [NAME] consult and did not realize Resident 1 already had an order for the Tylenol 8 hour three times per day. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR (Medication Administration Record) revealed on November 15, 2024 Resident 1 received 650 mg of Tylenol at 8:00 AM, 12:00 PM and 4:00 PM. Resident 1 also received 1000 mg of Tylenol at 4:00 PM. On November 16, 2024 Resident 1 received 650 mg at 8:00 AM, 12:00 PM and 4:00 PM. Resident 1 also received 1000 mg of Tylenol at 12:00 AM, 8:00 AM and 4:00 PM. On November 17, 2024 Resident 1 received 650 mg at 8:00 AM, 12:00 PM and 4:00 PM. Resident 1 also received 1000 mg of Tylenol at 12:00 AM, 8:00 AM and 4:00 PM. On November 18, 2024 Resident 1 received 650 mg at 8:00 AM, 12:00 PM and 4:00 PM. Resident 1 also received 1000 mg of Tylenol at 12:00 AM and 8:00 AM. Further review of the MAR revealed a note under the Tylenol order that read .do not exceed >3gm/24hr. The nurses adminstered the Tylenol and did not question or clarify that the total dose of Tylenol was greater than 3 gm (3000 mg) in 24 hours. According to Employee 1, the Resident 1 received over 15000 mg of Tylenol over three days, November 15-18, 2024. An interview with Employee 2 on December 23, 2024, at 10:51 AM, revealed the Resident should not have received more than 3000 mg per day due to concerns with liver damage. An interview with the Nursing Home Administrator (NHA) on December 23, 2024, at 10:11 AM, revealed Resident 1 was placed on alert charting for five days, vital signs were monitored for five days, and blood testing was performed once for two weeks. An additional interview with Employee 2, at approximately 11:00 AM, revealed no concerns with a review of Resident 1's laboratory testing and no concerns with a change in the Resident's condition based on the excessive amount of Tylenol administered by the Nursing Staff. A final interview with the NHA confirmed Employee 1 should have consulted the physician or Employee 2 to clarify the additional 1000 mg of Tylenol ordered by the consultant physician visit and signed off by Employee 2 on October 15, 2024. 28 Pa. Code 201. 18 (b) (1) Management 28 Pa. Code 211.12 (c) (d) (1) (2) (5) Nursing services