

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 05/02/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure each resident receives adequate supervision and assistance to prevent accidents and hazards for one of three residents reviewed (Resident 1).</p> <p>Findings Include:</p> <p>Review of the facility's policy, titled Elopement of Patient, recently revised October 24, 2022, defined elopement as .any situation in which the patient leaves the premises without the facility's knowledge and supervision .</p> <p>Review of Resident 1's clinical record revealed diagnoses that included Post Traumatic Stress Disorder (PTSD - A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event. The condition may last months or years, with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions) and bipolar disorder (a mental illness characterized by extreme and unusual shifts in mood, energy, and activity levels).</p> <p>Review of Resident 1's clinical record revealed a progress note dated March 25, 2025, that read Resident continues with confusion. OOB [out of bed] in his power wheelchair this shift. Continues to state he is leaving and waiting for his family to arrive to pick him up. Going though [through] things in bags. Offered to assist him to lay down and rest, he declined at this time . The progress notes continued, Resident remained in his room this shift- would not get into bed. Continued with packing his belongings stated he needed to be ready for when his ride arrived. Pleasant with writer but very difficult to redirect.</p> <p>Continued review of the interdisciplinary progress notes dated March 27, 2025, at 14:28 [2:28 PM], revealed Resident [Resident 1] exited the building in manual wheelchair. Receptionist was able to keep sight of resident at all times and staff was summoned to assist. Resident was hesitant to return inside facility, believes he is moving to Washington DC. Wander Guard was present on the left ankle, but did not alarm per staff report. Wander Guard was replaced on resident's wheelchair .</p> <p>A Wander Guard is defined as a system that relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alerts your caregivers.</p> <p>(continued on next page)</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Additional review of Resident 1's progress notes revealed documentation on March 27, 2025, at 20:37 [8:37 PM], Resident 1 was found in the parking lot near the main entrance by an activities staff member (Employee 9). She was unable to coax him back into the building and had other staff get help from the supervisors present this evening . The administrator, was called and updated about this evenings events.</p> <p>An interview with the Director of Nursing (DON) on April 24, 2025, at 10:32 AM, revealed Resident 1 recently had a change in condition and caused physical damage to the building, including hallways. The interview revealed Resident 1 was difficult to redirect and was not exhibiting behaviors known to his personality. The interview also revealed that although Resident 1 was fitted with a Wander Guard, Resident 1 knew the code to exit the building.</p> <p>An additional interview with the Registered Nurse (Employee 1) on April 24, 2025, at approximately 11:00 AM, confirmed Resident 1 was found in parking lot, without staff knowledge, and had known the code to exit the building.</p> <p>A final interview with the Nursing Home Administrator and DON on May 2, 2025, at 1:41 PM, revealed no additional information or explanation regarding Resident 1 being found outside of the building without staff knowledge on March 27, 2025, by Employee 9 according to the facility's interdisciplinary progress notes.</p> <p>28 Pa. Code 201.18 (b) (1) Management</p> <p>28 Pa. Code 211. 12 (d) (1) (2) (5) Nursing services</p>		