

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  09/16/2025
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)
F 0600  Level of Harm - Actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on clinical record review, review of facility policy, and staff interview, it was determined that the facility failed to ensure that residents were free from sexual abuse, which resulted in actual harm as evidenced by emotional distress and a vaginal wound for one of four residents reviewed for abuse (Resident 1). Findings include: Review of facility policy, Abuse Prohibition, revised October 24, 2022, revealed, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation for all patients. Sexual abuse is a non-consensual sexual contact of any type with a patient. It includes but is not limited to sexual harassment, sexual coercion, or sexual assault. Review of Resident 1's clinical record revealed diagnoses that included Alzheimer's disease (gradual loss of memory, thinking skills, and self-care abilities) and heart failure (occurs when the heart doesn't pump blood as well as it should). Review of Resident 1's most recent BIMS score (Brief Interview for Mental Status) dated August 26, 2025, revealed a score of 3 out of 15, indicating severe cognitive impairment. Review of Resident 2's clinical record revealed diagnoses that included Parkinson's Disease (movement disorder that affects the nervous system and worsens over time) and dementia (decline in cognitive functioning that affects memory, thinking, and social abilities). Review of Resident 2's most recent BIMS score, dated July 7, 2025, revealed a score of 11 out of 15, indicating moderate cognitive impairment. Review of facility incident report dated September 13, 2025, at 6:15 AM, revealed that two nurse aides were in Resident 1's room giving care to Resident 1's roommate when they heard crying from behind the curtain. When the curtain was drawn, they found Resident 2 laying naked beside Resident 1 in her bed. Resident 1's brief had been removed. Staff observed that Resident 2 had one arm around Resident 1, and his fingers were inserted into Resident 1's vagina. Staff immediately addressed Resident 2 who removed himself and returned to his room across the hallway. Review of Employee 1's (Nurse Aide) witness statement, undated, revealed, I and another aide went to get [Resident 1's roommate] out of bed. I went to look behind the curtain because [Resident 1] was crying. We then saw [Resident 2's] clothes all the way off and him play with her private parts. Review of Employee 2's (Nurse Aide) witness statement, dated September 13, 2025, revealed, Me and another CNA [Certified Nurse Aide] went to get [Resident 1's roommate] out a bed. She went to look behind the curtain because [Resident 1] was crying. We then saw [Resident 2's] clothes all the way off and [Resident 1's] diaper off and him play with her private parts. Review of Employee 3's (Licensed Practical Nurse) witness statement, dated September 13, 2025, revealed, Around 0615 I was using the bathroom and heard someone yelling 'Nurse!' When I came down the hallway to assess the situation, 3 CNA's told me that [Resident 2] was found in [Resident 1's room] with his clothes off laying in bed with [Resident 1], [Resident 1's] clothes and brief were off of her and CNA stated [Resident 2] had his hand in [Resident 1's] genital area. CNA stated that [Resident 1] was crying while [Resident 2] was touching her. CNAs removed [Resident 2] from [Resident 1's room] and notified me when they saw me in the hallway. I immediately notified RN [Registered Nurse] supervisor. Resident 1 was transported to the emergency department following the incident and a forensic exam was performed. Review of hospital visit documentation dated September 13, 2025, revealed that, upon exam, a small tear on the outside of Resident 1's labia (part of the external female genitalia) was discovered. At the time of the incident, both Resident 1 and Resident 2 resided on the locked memory care unit. Resident 1 was moved to another nursing unit on September 13, 2025, and Resident 2 was placed on 1:1 supervision following the incident. During an interview with the Nursing Home Administrator on September 16, 2025, at 1:47 PM, he revealed that it's the facility's goal that residents are free from abuse. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1) Nursing services</p>		