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	01/02/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, policy review, and resident and staff interviews, it was determined that the facility failed to ensure each resident is treated with respect, care, and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality, for one of eight residents observed (Resident 6). Findings Include:Review of the facility's policy, titled Resident Rights Under Federal Law, reviewed June 12, 2025, read, in part, that the purpose of the policy is To treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their self-esteem and self-worth. The policy continued, To protect and promote the rights of the resident.Review of Resident 6's clinical record revealed diagnoses that included congestive heart failure (a chronic condition where the heart muscle weakens or stiffens, making it unable to pump enough oxygen-rich blood to meet the body's demands, leading to fluid buildup [congestion] in the lungs, legs, and other organs, causing symptoms like shortness of breath, swelling, and fatigue) and community-acquired pneumonia (a lung infection caught outside hospitals, causing symptoms like cough [with phlegm], fever, chills, and shortness of breath, trigged by bacteria, viruses or fungi. It's a common and serious illness, especially for the elderly, and treatment often involves antibiotics, though viral causes may need supportive care.)Resident 6 was being admitted to the facility, on December 29, 2025, at 12:43 PM. Observation revealed a transportation team attempting to admit Resident 6 into a room already occupied by Resident 8.The observation prompted the Licensed Practical Nurse (Employee 3) to immediately yell, She can't go in there because she's Black. Employee 3 attempted to make telephone contact with the admissions team regarding the placement of Resident 6 in the room with Resident 8.Resident 6 was removed from the room by the transport team and presented to the nurses' station desk via stretcher. The transport person informed the staff that Resident 8 began yelling and called Resident 6 a n***** (a derogatory racial slur most often levied towards Black Americans).Resident 6 was transferred by the transport team to another area and room within the facility with the assistance and interventions of Employee 3.An interview with Employee 3, on December 29, 2025, at approximately 12:50 PM, revealed that staff have knowledge that Resident 8 is described as racist and that the staff intervene to prevent incidents or disruptions based on that knowledge. The interview also revealed that the staff are typically notified prior of admissions and would have informed staff not to admit Resident 6 to Resident 8's occupied room. An interview with Resident 6 on December 29, 2025, at 12:57 PM, revealed that Resident 8 indeed called her the racial slur, and Resident 6 stated, That was the last thing I expected. The interview revealed Resident 6 planned on participating in rehabilitation care and services, with a goal to return home with her daughter as soon as possible.An interview with the Director of Nursing and the Administrator in Training (Employee 6) on December 29, 2025, at approximately 1:40 PM, revealed that the Director of Admissions (Employee 5) was not present for work on that date. The interview revealed the facility will review its process for new admissions to determine how such an interaction could have been prevented. 28 Pa. Code 201.18 (b) (1) Management28 Pa. Code 201.29 (c) (c.3) (4) Resident rights

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and staff interview, it was determined that the facility failed to post the current daily nurse staffing information that included the facility name, current date, resident census, and the total number of direct care hours for licensed and unlicensed nursing staff, for one posted nurse staffing document observed (facility lobby). An observation of the facility's nurse staffing information, on December 29, 2025, at approximately 8:30 AM, revealed the most recent posting with information dated December 27, 2025.An interview with the Administrator in Training (Employee 1), on December 29, 2025, at 9:41 AM, confirmed that the posted information should have been updated by the night shift staff and weekend staff. The interview revealed the posted information would be updated immediately to reflect the current date and other required information.28 Pa. Code 201.14 (a) Responsibility of licensee

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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. Based on document review, clinical review, and staff interview, it was determined that the facility failed to obtain diagnostic services to meet the needs of its residents and ensure those services are obtained promptly for one of two residents reviewed for falls (Resident 1).Findings Include:Review of Resident 1's clinical record revealed diagnoses that included Right Femur Fracture and Alzheimer's Disease (a progressive brain disease, the most common cause of dementia, that gradually destroys memory, thinking, and reasoning skills, leading to severe memory loss, confusion, and difficulty with daily tasks, behavior changes, and eventual inability to carry out even simple activities).Review of Resident 1's falls, during December 2025, revealed a fall dated December 7, 2025. According to the incident report, staff documented the following immediate action: the Certified Registered Nurse Practitioner (CRNP) notified and ordered STAT x-ray R [hip] . The time noted of the notification to the CRNP was documented as 9:20 PM.In medical terms, STAT is defined as immediately or right away. Review of the document, titled Preventive Diagnostics, dated the following day, December 8, 2025, revealed the facility's contracted mobile X-Ray provider performed the X-ray on Resident 1 at 12:09 PM.The X-ray read right subcapital hip fracture is noted. Osteopenia [reduced bone mass] noted. Fracture as noted of unknown chronicity.Electronic mail correspondence, with the Director of Nursing, on December 31, 2025, at 1:05 PM, revealed The x-ray was entered incorrectly. It was entered as one-time only instead of stat. The X-ray company states that the turnaround time for stat requests is four hours. We have notified all providers that in-house stat X-rays will not be done related to the turnaround time, and if it is necessary to obtain the X-ray stat, the resident will need to be sent to the hospital.28 Pa. Code 211.12 (d) (5) Nursing services

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on a clinical record, policy review, and staff interview, it was determined that the facility failed to ensure that residents received routine dental services for one of six resident records reviewed (Resident 4). Findings Include:Review of the facility's policy, titled Dental Services, revised on September 15, 2025, reads, in part, Centers [facility] will provide or obtain from an outside resource routine and emergency dental services, including 24-hour emergency dental care, to meet the needs of each patient.The policy continued, Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures.Review of Resident 4's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic pain, with an admission date to the facility of November 1, 2022.Review of Resident 4's interdisciplinary plan of care revealed documentation that included an identified problem for a potential for dental or oral cavity health problem d/t [due to] aging teeth. Continued review of Resident 4's clinical record revealed no dental consultations for access to routine and/or emergent dental care since the admission date in 2022.Electronic Mail correspondence with the Administrator in Training (Employee 1) and the Director of Nursing on December 30, 2025, at 1:35 PM, confirmed Resident 4 had not been seen by a dentist for routine care, and the facility is attempting to seek means to have the Resident signed up for routine and/or emergent dental services.28 Pa. Code 201.18 (a) Management28 Pa. Code 211.12 (d) (5) Nursing services