

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/28/2026
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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documentation provided by the facility, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure one of five residents reviewed was free of verbal abuse (Resident 5). Findings include: Review of facility policy, titled Abuse Prohibition, revised November 14, 2025, read, in part, the center will implement an abuse prohibition program through screening of potential hires; prevention of occurrences; identification of possible incidents or allegations which require investigation; investigation of incidents; protection of residents during investigation; and reporting incidents, investigations and facility response to the results of their investigations. Review of Resident 5's clinical record documented diagnoses that included osteoarthritis (degenerative joint disease where the protective tissue cushioning the ends of the bones wears away, causing joint pain), polyneuropathy (peripheral nerves throughout the body or damaged or malfunctioning at the same time causing numbness, tingling and weakness in the hands and feet), depression (feelings of severe despondency and dejection), anxiety (a feeling of worry, nervousness, or unease), and muscle weakness. Review of Resident 5's care plan documented that she requires two-person assistance with transfers. Review of facility provided information revealed Employee 1 (Nursing Assistant) requested assistance from Employee 2, (Nursing Assistant) in returning Resident 5 back into bed. Employee 1's statement revealed that upon Employee 2 entering the Resident's room, Employee 2 spoke to the Resident in an aggressive and inappropriate manner; allegedly telling the Resident to shut up and referring to the Resident as a b*tch. Employee 1 reported that after the Resident was transferred into bed, Employee 2 handled the Resident roughly while repositioning her. Employee 1's statement further documented that as Resident 5 was speaking, Employee 2 placed her hand over the Resident's mouth and stated, shut the f*ck up. Employee 1 reported the incident immediately. Registered Nurse assessment was completed, no injury noted. Employee 2 was escorted from the facility, pending the investigation. During the facility's interview, Employee 1 stated that she instructed Employee 2 to leave the room and she could finish the Resident's care. Employee 2 then proceeded to tell Resident 5 that she didn't like her and instructed the Resident to shut up. Shortly thereafter, Employee 2 received a telephone call and exited the room. The facility's interview with Resident 5 revealed the same account of interactions with Employee 2. Resident 5 was her own representative and was notified of the actions being taken. Employee 2 was interviewed and denied doing anything. The attending physician, [NAME] County Office of Aging, and the [NAME] Regional Police Department were notified. The police interviewed Resident 5, who didn't wish to press charges. Employee 2 was terminated and was reported to the PA State Licensing Board. The Department of State Professional Compliance Office emailed a letter to the Director of Nursing on July 22, 2026, to inform the facility that their reported complaint was forwarded to the PA (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 395451	Facility ID: 395451 If continuation sheet Page 1 of 4

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dept of Health because the licensing board has no jurisdiction over Nursing Assistants. Abuse training in the facility's Health Stream system was initiated in January 2026; Employee 2 completed the training on January 29, 2026. Interview with Resident 5 on July 27, 2026, at 11:50 AM, revealed she had no concerns post incident. She stated that was the first and only incident with a staff member. The staff treat her well, and she receives the care she needs. She felt the facility handled the investigation timely, was satisfied with the facility investigation and response to incident. She confirmed she didn't sustain any injury, feels fine psychosocially, and feels safe in the facility. Interview with the Nursing Home Administrator on July 27, 2026, at 3:45 PM, revealed that abuse prevention is taken seriously, that is why it is reviewed multiple times throughout the year. It was also revealed that if Employee 2 needed to take a break, she should've excused herself. 28 Pa. code 201.14(a) Responsibility of Licensee28 Pa. code 201.18(b)(1) Management28 Pa. Code 201.29(c) Resident rights28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on facility policies, review of the clinical record, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs of the resident for one of five residents reviewed (Resident 1). Findings include: Review of facility policy, titled Medication Errors, revised July 1, 2024, read, in part, a medication error includes medication administered not in accordance with the prescriber's order to include the incorrect medication. Review of facility policy, titled Falls, revised March 15, 2024, read, in part, evaluate the resident for injury post-fall and provide appropriate and timely care, notify the physician of the fall report physical findings and extent of injuries. Any resident who sustains an injury to the head from a fall will be observed for neurological abnormalities by performing neurological check. The physician will be notified of an abnormal finding. The Resident Representative will be notified of the fall and any follow-up treatment. Review of facility policy, titled Change in Condition, revised July 1, 2024, read, in part, the facility must immediately inform the resident's physician and the resident representative when an accident involving the resident which results in injury and has the potential for requiring physician intervention. To provide appropriate and timely information about changes relevant to the residents' condition. Review of Resident 1's clinical record documented diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement), hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles) left non-dominant side, history of falling, and dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking). Review of the medication error report dated July 20, 2026, at 10:00 PM, documented Resident 1 took a medication cup containing apple sauce and one melatonin pill off the top of the medication cart and ingested it. He was assessed at the time of the incident, no injury noted. Review of Resident 1's clinical record revealed that no Neurological checks or alert charting were initiated. The Certified Registered Nurse Practitioner (CRNP) was notified on July 20, 2026 at 11:58 PM; however, the medication error report documented that the Resident Representative wasn't notified until July 21, 2026, at 6:35 AM. Review of the fall report dated July 20, 2026, at 11:00 PM, documented Resident 1 was found on the floor alongside his bed. He was assessed at that time and sustained an abrasion to his scalp and a hematoma to his face. Neurological checks were initiated and within normal limits. Progress note dated July 20, 2026, at 11:21 PM, documented Resident 1 had an unwitnessed fall and that the provider and Responsible Party were notified. Review of the fall report for July 21, 2026, at 2:50 AM, documented Resident 1 was found on the floor alongside his bed. He was assessed at the time, and no additional injuries were noted. Neurological checks were re-started and initially were within normal limits. However, at 8:35 AM, Resident 1 went from being alert to being drowsy, and his pupils being equal round and reactive to light to being pinpoint. The CRNP was notified at 6:46 AM (contact was made at that time), however, there was no documentation the CRNP was informed of the change in the Resident's neurologic status. The medication error report document the Resident Representative wasn't notified at that time; documented time of notification July 21, 2026, at 6:35 AM. Progress note dated July 21, 2026, at 3:40 AM, documented when completing neurological checks, the Resident was found on the floor next to his bed; will pass on to next shift to notify the provider and the Responsible Party. Progress note dated July 21, 2026, at 8:54 AM, documented the Resident was not able to take his medications at that time because he was very drowsy. Review of the fall report for July 21, 2026, at 10:00 AM, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented Resident 1 was found on the floor alongside his bed. He was assessed at that time, and pupils were pinpoint and nonreactive. It was noted that the provider and daughter were contacted, a time wasn't documented. The Resident was sent to the Emergency Room. Facility reported event to the Department of Health on July 21, 2026, also documented mental status noted to be altered as the Resident wasn't responding to verbal or tactile simulation. Review of emergency room (ER) Summary report dated July 21, 2026, documented Resident 1 was transferred to the ER due to lethargy and pinpoint pupils. The Resident wasn't on a blood thinner, however, the Resident reported he got a different Resident's medications last night. He had a bruise on his left flank and abrasions on his right forehead. Pupils are equal and reactive to light, 2 mm. Hypertensive, hypothermic, and tachypneic (rapid and shallow breathing). Computed Tomography (CT) scan of head and chest was unremarkable. Sepsis workup revealed infection, source unclear; broad spectrum antibiotics ordered. Resident admitted to the hospital for hypothermia. Interview with Nursing Home Administrator (NHA) on July 27, 2026, at 2:37 PM, revealed the facility had a meeting with one of their providers offices because it was taking a long time for the practitioners to return calls to the facility due to staff were on vacation that week. NHA assumed the time documented as notified the MD/CRNP was the actual the time they spoke with someone. Interview with Director of Nursing (DON) on July 27, 2026, at 3:25 PM, revealed a Nurse can make the judgement to send a Resident out to the hospital without a physician's order. The DON was not sure why the nurse didn't feel it was necessary to send the Resident out when there was a neurological change. Per email communication with DON on July 28, 2026, at 12:17 PM, it was revealed nursing should have notified the provider when the change in condition was noted. It had been addressed internally through the facility performance improvement process and house wide education. It was also revealed that Resident 1 was documented as a do not resuscitate with comfort as the goal, so the Registered Nurse Supervisor did not feel as though transfer was warranted at the time. The supervisor has since been educated. Interview with the NHA and don on July 28, 2026, at 1:00 PM, the surveyor revealed the concern that the Resident Representative was notified timely of the medication error and two falls. No further information was provided. The facility failed to notify the provider timely of a change in neurologic condition and failed to notify the family timely regarding the medication error and two falls; one of which Resident 1 sustained a laceration and hematoma. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(a)(c) Resident care policies28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services		