

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395451	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/31/2025
NAME OF PROVIDER OR SUPPLIER: INNERS CREEK SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WEST QUEEN STREET DALLASTOWN, PA 17313		
STATE LICENSE NUMBER: 900802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Revisit Survey completed on January 30, 2025, it was determined that Inners Creek Skilled Nursing and Rehabilitation Center had not corrected the deficiencies cited during the survey of December 10, 2024, under the requirements of 28 PA code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<ol style="list-style-type: none"> 1. All residents received care in accordance with their plan of care and attending physician orders. 2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. 3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. 4. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. Results will be taken to the QAPI for review and revision as needed. 	<p>Completion Date: 03/11/2025</p> <p>Status: APPROVED</p> <p>Date: 02/06/2025</p>

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P 5520	Continued from page 1 Based on staffing documents and staff interview, it was determined that the facility failed to ensure a required minimum of one Nurse Aide (NA) per 10 residents on day shift (January 28, 2025), one NA per 11 residents on evening shift (January 26, 2025), and one NA per 15 residents on overnight shift (January 23, 24, 25, 26, 27, and 29, 2025). Findings include: Review of facility staffing ratio and resident census information for January 23 through 29, 2025, revealed the following NA ratios, which did not meet the minimum NA ratio required for the resident census on the following shifts: January 23, 2025, night shift - 188 residents and 10.0 NAs on night shift, which didn't meet the required ratio of 12.53. January 24, 2025, night shift -192 residents and 9.0 NAs on night shift, which didn't meet the required ratio of 12.80. January 25, 2025, night shift -191 residents and	P 5520		

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P 5520	Continued from page 2 9.40 NAs on night shift, which didn't meet the required ratio of 12.73 on night shift . January 26, 2025, evening and night shifts - 188 residents and 16.40 NAs on evening shift, which didn't meet the required ratio of 17.09. Night shift 188 residents and 9.53 NAs, which didn't meet the required ratio of 12.53. January 27, 2025, night shift -189 residents and 10.40 NAs on night shift, which didn't meet the required ratio of 12.60. January 28, 2025, day shift - 189 residents, and 18.69 NAs on day shift, which didn't meet the required ratio of 18.90. January 29, 2025, night shift - 182 residents, and 11.00 NAs on night shift, which didn't meet the required ration of 12.13. During an electronic communication with the Nursing Home Administrator on January 31, 2025, at 12:00 PM, it was confirmed the facility had not met the staffing requirements. It was also noted that the facility had 30 vacant NA positions, and that the facility was utilizing multiple agencies to fill vacancies.	P 5520		

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P 5640	<p>Nursing services.</p> <p>(2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5640	<ol style="list-style-type: none"> All residents received care in accordance with their plan of care and attending physician orders. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff. All Nursing Staff will be educated on the Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted. To monitor and maintain ongoing compliance the DON or designee will audit staffing weekly x4 weeks then monthly for two months. Results will be taken to the QAPI for review and revision as needed. 	<p>Completion Date: 03/11/2025</p> <p>Status: APPROVED</p> <p>Date: 02/06/2025</p>

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P 5640	Continued from page 4 Based on staffing documents and staff interview, it was determined that the facility failed to ensure the total number of nursing care hours provided in each 24-hour period be a minimum of 3.20 hours of direct care for each resident for six of seven days reviewed (January 23, 24, 25, 26, 27, and 28, 2025). Findings Include: Review of one week of facility staffing hours that included January 23 through 29, 2025, revealed that the facility provided less than the required 3.20 hours of direct care per resident on the following dates: January 23 - 3.10; January 24 - 3.00; January 25 - 2.99; January 26 - 2.91; January 27 - 2.93; and January 28 - 3.07. During an electronic communication with the Nursing Home Administrator on January 31, 2025, at 12:00 PM, it was confirmed the facility had not met the staffing requirements.	P 5640		



Certified End Page

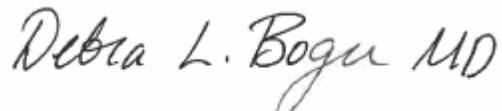
INNERS CREEK SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 900802

SURVEY EXIT DATE: 01/31/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY