

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/07/2025
NAME OF PROVIDER OR SUPPLIER  Mill Creek Center for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4911 Brian Center Lane Winston-Salem, NC 27106	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>49007</p> <p>Based on record review, and staff, Nurse Practitioner (NP) and physician interviews, the facility failed to notify the physician when an anticonvulsant medication was not administered for 1 of 1 resident reviewed for notification (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility 11/27/24 with diagnoses that included stroke, nontraumatic subdural hemorrhage unspecified, and seizure disorder of epilepsy.</p> <p>Resident #1's Physician's orders included an order written 11/29/24 for Valproic Acid Oral Solution 250mg (milligrams)/5 ml (milliliters) solution to give 15ml by mouth every 8 hours for seizures.</p> <p>Resident #1's Medication Administration Records (MAR) for 11/2024 and 12/2024 were reviewed and revealed the following: Valproic Acid Oral Solution 250 mg/5ml solution was not signed on the MAR as given at 2:00 pm on 12/3/24, 12/5/24, 12/7/24, 12/10/24 and 12/12/24. Further review of the MARs revealed on 12/3/24 Nurse #3 documented Hold/See Nurse Notes, on 12/5/24 Nurse #2 documented LOA (leave of absence), on 12/7/24 Nurse #4 documented Other/See Nurse Notes, on 12/10/24 and 12/12/24 Nurse #1 documented Other/See Nurse Notes.</p> <p>Further review of Resident #1's medical record and nursing notes revealed there was no documentation the physician was notified on 12/3/24, 12/5/24, 12/7/24, 12/10, 24 or 12/12/24 of the Valproic Acid not being administered.</p> <p>Review of Resident #1's MAR on 12/3/24 at 2:00pm revealed Resident #1 did not receive Valproic Acid and Nurse #3 indicated hold/see nurse notes. Nurse #3's note on 12/3/24 at 3:16pm read in the dialysis.</p> <p>During a phone interview on 1/3/25 at 2:13pm, Nurse #3 revealed that she didn't remember Resident #1 and could not answer any questions.</p> <p>Review of Resident #1's MAR on 12/5/24 at 2:00pm revealed that Valproic Acid was not given, and Nurse #2 documented Resident #1 was on Leave of Absence (LOA).</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 1/3/25 at 3:22pm, Nurse #2 revealed that she didn't remember Resident #1 well, but Valproic Acid was not given on 12/5/24 due to Resident #1 being at dialysis. Nurse #2 indicated she would have told the NP if medication was held, although she really didn't recall.</p> <p>Nurse #4's progress noted dated 12/7/24 at 1:20pm did not reveal why Valproic Acid was not administered.</p> <p>During a phone interview on 1/4/25 at 4:20pm, Nurse #4 revealed that she was fairly new to the facility, and she didn't recall Resident #1.</p> <p>Resident #1's MAR on 12/10/24 revealed Resident #1 did not receive Valproic Acid at 2:00pm and read other/see nurse notes. Resident #1's MAR on 12/12/24 revealed Resident #1 did not receive Valproic Acid at 2:00pm and read other/see nurse notes. Nurse #1's progress note on 12/12/24 at 2:32pm read he is on dialysis.</p> <p>Nurse #1's progress note on 12/10/24 at 4:52pm revealed Resident #1 returned from dialysis at 4:45pm.</p> <p>During an interview on 1/3/25 at 11:38am, Nurse #1 confirmed that Valproic Acid was not administered on 12/10/24 and 12/12/24 and he wrote a progress note that Resident #1 was at dialysis. Nurse #1 indicated he didn't notify the physician because he wrote the note as he thought it was known that Resident #1 was at dialysis.</p> <p>During an interview on 1/3/25 at 10:08am, the Unit Manager revealed that Resident #1 missed the midday dose of Valproic Acid on 12/3/24, 12/5/24, 12/7/24, 12/10/24, and 12/12/24 due to being at dialysis. She was unsure if the physician was aware of missed doses.</p> <p>During an interview on 1/3/25 at 9:18am, NP revealed that she was not aware that Resident #1 missed several doses of his Valproic Acid that was scheduled while Resident #1 was at dialysis. The NP indicated the physician may have been aware of the missed doses and NP would have wanted Resident #1's medications given as ordered.</p> <p>During a phone interview on 1/3/25 at 10:47am the Physician revealed she was aware that Resident #1's midday Valproic Acid was scheduled during the time when Resident #1 would be at dialysis.</p> <p>During a phone interview with the Interim Director of Nursing on 1/6/25 at 4:30pm she indicated she expected medications to be given as ordered and if they were not given as ordered the physician needed to be notified.</p> <p>During a phone interview with the Administrator on 1/6/25 at 4:44pm she indicated that she expected medications to be given as ordered and if they were not given as ordered the physician needed to be notified.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49007</p> <p>Based on record review and staff, Pharmacist, Nurse Practitioner (NP) and Physician interviews, the facility failed to prevent a significant medication error when they failed to administer antiseizure medication as prescribed by the physician. As a result, Resident #1 missed 5 doses of antiseizure medication. This affected 1 of 3 sampled residents reviewed for assuring facility was free of medication errors (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included stroke, nontraumatic subdural hemorrhage unspecified, and seizure disorder or epilepsy.</p> <p>Resident #1's Care Plan dated 11/30/24 indicated he had a seizure disorder, and the interventions included administer seizure medication as ordered and monitor for effectiveness.</p> <p>Resident #1's Physician's orders included an order written 11/29/24 for Valproic Acid Oral Solution 250mg (milligrams)/5ml (milliliter) solution to give 15 milliliters by mouth every 8 hours for seizures.</p> <p>Resident #1's Medication Administration Records (MAR) for 11/2024 and 12/2024 were reviewed and revealed the following: Valproic Acid Oral Solution 250 mg/5ml solution was not signed on the MAR as given at 2:00 pm on 12/3/24, 12/5/24, 12/7/24, 12/10/24 and 12/12/24. Further review of the MARs revealed on 12/3/24 Nurse #3 documented Hold/See Nurse Notes, on 12/5/24 Nurse #2 documented LOA (leave of absence), on 12/7/24 Nurse #4 documented Other/See Nurse Notes, on 12/10/24 and 12/12/24 Nurse #1 documented Other/See Nurse Notes.</p> <p>Review of Resident #1's MAR on 12/3/24 at 2:00pm revealed Resident #1 did not receive Valproic Acid and Nurse #3 indicated hold/see nurse notes. Nurse #3's note on 12/3/24 at 3:16pm read in the dialysis.</p> <p>During a phone interview on 1/3/25 at 2:13pm, Nurse #3 revealed that she didn't remember Resident #1 and could not answer any questions.</p> <p>Review of Resident #1's MAR on 12/5/24 at 2:00pm revealed that Valproic Acid was not given, and Nurse #2 documented Resident #1 was on Leave of Absence (LOA).</p> <p>During a phone interview on 1/3/25 at 3:22pm, Nurse #2 revealed that she didn't remember Resident #1 well, but Valproic Acid was not given on 12/5/24 due to Resident #1 being at dialysis. Nurse #2 indicated she would have told the NP if medication was held, although she really didn't recall.</p> <p>Nurse #4's progress noted dated 12/7/24 at 1:20pm did not reveal why Valproic Acid was not administered.</p> <p>During a phone interview on 1/4/25 at 4:20pm, Nurse #4 revealed that she was fairly new to the facility, and she didn't recall Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 MAR on 12/10/24 revealed Resident #1 did not receive Valproic Acid at 2:00pm and read other/see nurse notes. Nurse #1's progress note on 12/10/24 at 4:52pm revealed Resident #1 returned from dialysis at 4:45pm. Resident #1's MAR on 12/12/24 revealed Resident #1 did not receive Valproic Acid at 2:00pm and read other/see nurse notes. Nurse #1's progress note on 12/12/24 at 2:32pm read he is on dialysis.</p> <p>During an interview on 1/3/25 at 11:38am, Nurse #1 confirmed that Valproic Acid was not administered on 12/10/24 and 12/12/24 and he wrote a progress note that Resident #1 was at dialysis. Nurse #1 indicated he didn't notify the physician because he wrote the note as he thought it was known that Resident #1 was at dialysis.</p> <p>During an interview on 1/3/25 at 10:08am, the Unit Manager revealed that Resident #1 missed the midday dose of Valproic Acid on 12/3/24, 12/5/24, 12/7/24, 12/10/24, and 12/12/24 due to being at dialysis. She was unsure if the Physician was aware of missed doses.</p> <p>A follow-up interview on 1/4/25 at 3:31pm with Unit Manager revealed Resident #1 went to dialysis on Tuesdays, Thursdays and Saturdays. Resident #1 had a chair time of 9:50am and was usually away from the facility between 5 - 6 hours.</p> <p>During an interview on 1/3/25 at 9:18am, NP revealed that she was not aware that Resident #1 missed several doses of Valproic Acid that were scheduled while Resident #1 was at dialysis and would have wanted Resident #1's Valproic Acid given as ordered.</p> <p>During a phone interview on 1/3/25 at 10:47am, Physician revealed she was aware that Resident #1's midday Valproic Acid was scheduled during the time when Resident #1 would be at dialysis. The interview further revealed she didn't feel like the missed medications were harmful to him and to her knowledge he didn't have any seizures at the facility.</p> <p>During a phone interview with the Pharmacist on 1/3/25 at 3:55pm she indicated that missing a dose of Valproic Acid would not have made Resident #1 subtherapeutic, Resident #1 would have had to have missed several doses in a row; Valproic Acid has 16-hour half-life. The interview further revealed missing one dose would not have caused Resident #1 to have a seizure.</p> <p>During a phone interview with the Interim Director of Nursing on 1/6/25 at 4:30pm she indicated Resident #1 didn't have any seizures while in the facility and she felt like the missed doses did not negatively affect Resident #1 in the short-term. The interview further revealed that she expected medications to be given as ordered and if they were not given as ordered the physician needed to be notified.</p> <p>During a phone interview with the Administrator on 1/6/25 at 4:44pm she indicated that she expected medications to be given as ordered and if they were not given as ordered the physician needed to be notified.</p>		