STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366370	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Creek Nursing & Rehabilitation	900 Wedgewood Circle Galion, OH 44833

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on observation, record review and interview the facility failed to ensure call lights were within reach and accessible. This affected two residents (Resident #17 and #66) of two residents reviewed for call light accessibility. The census was 71. Findings Include: 1. Record review revealed Resident #17 was admitted on [DATE] to the facility with diagnoses that included but not limited to hypertensive heart disease, polyarthritis, and general anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had moderately impaired cognition and required supervision of activities of daily living. Review of care plans dated 08/25/22 revealed Resident #17 had a potential risk for falls related to decreased mobility and incontinent of bowel and bladder. Interventions included but not limited to encourage and remind to ask for assistance and have commonly used articles within easy reach. Observation of Resident #17 on 02/09/25 at 10:16 A.M. revealed Resident #17 was in her wheelchair. There were two call lights in Resident #17's private room. The one call light was coming off the wall and the button to that call light was on the floor. The other call light was a soft touch pad and was hanging on the wall. Observation revealed both call lights were not within reach. This was verified by Medical Records #205. 2. Record review revealed Resident #66 was admitted on [DATE] and a readmitted [DATE] to the facility with diagnoses that included but not limited to atherosclerosis, Alzheimer's disease, and general anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #66 had severely impaired cognition and required moderate assistance for activities of daily living. Review of care plans dated 08/12/24 revealed Resident #66 had a potential risk for falls related to decreased mobility and history of falls. Interventions included but not limited to encourage soft touch call light with glow tape and have commonly used articles within easy reach. Observation on 02/09/25 at 9:50 A.M. revealed that Resident #66 was lying in her bed, her soft touch pad was sitting on the nightstand, and her telephone was off the hook on the floor and under the bed. This was verified by the Assistant Director of Nursing #208 on 02/09/25 at 9:52 A.M.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528 Based on observation, medical record review, staff interview and review of the facility policy, the facility failed to ensure oxygen was administered per physician orders and failed to ensure oxygen tubing was dated when initiated/changed. This affected two (#23 and #31) of eight residents reviewed for oxygen administration. The facility identified eight residents who received oxygen therapy. The facility census was 71. Findings include: 1. Review of the medical records for resident #23 revealed an admitted [DATE] with the following but not limited to diagnoses of: respiratory failure, Parkinson's disease, dysphagia, and pneumonia. Resident #23 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of five out of 15 noted on 01/10/24. Resident #23 required assistance with activities of daily living (ADLs) tasks including medication administration and the use of a wheelchair for mobility. Review of Resident #23's physician orders dated 02/09/25 revealed an order for oxygen continuous at two to four liters per minute via per nasal cannula to maintain saturation above 90% (normal above 90%). There were no orders for nasal cannula (oxygen tubing) maintenance/care Further review of the medical record revealed on 02/09/25 at 5:10 P.M. the resident was receiving oxygen via nasal cannula at 2 LPM and his oxygen saturation was 99%. On 02/10/25 it was documented under vital signs that Resident #23 was receiving oxygen via nasal cannula at 2 LPM via NC. An observation on 02/09/25 at 10:59 A.M. revealed Resident #23 was seated in his wheelchair in his room with oxygen via nasal cannula being administered at a rate of 1 LPM. No date was noted on the oxygen tubing. Resident #23 was resting with his eyes closed and no respiratory distress was noted. An observation on 02/10/25 at 9:10 A.M. revealed Resident #23 was in bed, resting with eyes closed, with oxygen via nasal cannula at a rate of 1 LPM. An interview on 02/10/25 at 9:13 A.M. with Registered Nurse (RN) #76 confirmed Resident #23's oxygen was running at a rate of 1 LPM when the order read to administer the oxygen at 2-4 LPM. Also confirmed with RN #76 that there was no order in the electronic medical record (EMR) to change the oxygen tubing/nasal cannula. 2. Review of the medical record of Resident #31 revealed an admitted [DATE], with diagnosis including but not limited to chronic respiratory failure with hypoxia, unspecified asthma, and chronic atrial fibrillation. Resident #31 had a Brief Interview of Mental Status (BIMS) score of 14 out of 15 indicating intact cognition. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed on 11/22/24 under progress notes it was noted that Resident #31 was placed on 2 liters of oxygen after her oxygen level was 87% on room air. There were no orders written for oxygen, or notification to the physician documented. On 12/8/24 at 9:22 P.M. it was documented in the EMR under vitals Resident #31 was on oxygen via nasal cannula with an oxygen saturation of 94%,. On 12/09/24 at 11:10 P.M. it was documented under the vitals that Resident #31 was on oxygen via nasal cannula with an oxygen concentration of 93%, with no flow rate or progress note was noted in the EMR. Further review of the medical record revealed no evidence the physician was notified of Resident #31's shortness of breath and/or low oxygen saturation levels. Observation on 02/09/25 at 2:06 P.M. in the room of Resident #31 revealed an oxygen concentrator with tubing connected to the oxygen concentrator and a humidifier containing water also connected, next to the residents recliner chair plugged into the wall. The oxygen tubing was not dated. When asked by this writer if Resident #31 used oxygen the resident stated Yes I do when I am feeling short of breath. Interview with the Director of Nursing (DON) at 8:50 A.M. on 02/12/25 revealed the facility's policy is after someone is placed on oxygen, they are to update the doctor and place an order in the electronic medical record. The. DON also verified the above findings in regard to Resident #31 not having orders for oxygen including when to change the tubing. Review of the facility policy titled, Oxygen Administration, dated 07/30/24, revealed , Oxygen tubing and mask/cannula may be changed weekly and as needed if it becomes contaminated or soiled. Oxygen is administered under the orders of a physician.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, record review, and interview, the facility failed to honor Resident #185's food preferences. This affected one (Resident #185) of four residents reviewed for food and nutrition. Facility census was 71. Findings include: Review of the medical record revealed Resident #185 was admitted on [DATE] with diagnoses that included urinary tract infection, asthma, and type 2 diabetes. The Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #185 was cognitively intact. The MDS also revealed Resident #185 received a regular diet. The care plan dated 01/28/25 revealed Resident #185 had the potential for alteration in nutrition and hydration. Interventions included to honor food/beverage preferences as able and provide the diet as ordered. A physician order dated 02/03/25 revealed Resident #185 was ordered a low concentrated sweets diet and regular texture. Observation on 02/11/25 at 11:20 A.M. revealed Resident #185's meal ticket had spinach and greens listed as dislikes. Dietary Personnel #231 placed a bowl of collard greens on Resident #185's meal tray. When questioned about Resident #185's dislikes, Dietary Personnel #231 stated Resident #185 did not have to eat the collard greens and could ask for something else when Resident #185's tray was delivered. Resident #185's meal tray, with the collard greens still on the meal tray, was loaded onto the cart to be delivered. On 02/11/25 at 11:22 A.M. Dietary Manager #210 verified food preferences were to be honored. Dietary Manager #210 instructed the dietary staff to replace the collard greens with a salad on Resident #185's meal tray. Interview on 02/11/25 at 1:18 P.M. Resident #185 verified they did not like spinach, greens, or collard greens.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34298 Based on observation and interview, the facility failed to ensure thickener and flour were properly stored. This had the potential to affect three residents (#23, #33, and #73) that received pureed diets and 14 residents on mechanical diets. Facility census was 71. Findings include: A tour of the kitchen on 02/09/25 at 8:21 A.M. revealed two large square containers with the lids off. The containers were located on the bottom shelf of a table that held the immersion blender. One container was labeled flour and one was labeled thickener. No food was being blended or prepared at the time. On 02/09/25 at 8:55 A.M. Dietary Manager #210 verified the containers with flour and thickener were not properly covered.