

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2024
NAME OF PROVIDER OR SUPPLIER  Millcreek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  5535 Peach Street Erie, PA 16509	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42655</p> <p>Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to implement their established procedures for investigation and protection of residents in response to potential abuse for one of two residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Facility policy, Abuse and Neglect dated 1/10/24, revealed It is the policy to have zero tolerance for incidents of abuse and/or neglect. The purpose of the policy is to show that all allegations of abuse/neglect will be thoroughly investigated and reported to the appropriate County, State and Federal agencies pursuant to Federal regulations to include: screening, training, prevention, identification, investigation, protection, and reporting. Procedure: Identifying/Reporting/Investigating/Protection: Staff witnessing any incident of alleged abuse or neglect of Residents are required to report the incident to the supervisor immediately. The nursing supervisor will have the staff witnessing write a detailed account of the event, then sign and date. The supervisor will notify the Director of Nursing, who will notify the Administrator. The employee who has been accused will be informed of the allegation, asked to give a written statement (including signature, date, and time) and will be suspended pending investigation. If the allegations are found to be substantiated, the employee will be terminated and reported to the appropriate agency for disposition. If the allegations are not substantiated, the employee may resume their normal duties. Training/Prevention: All staff will be proficient in the reporting of abuse and neglect.</p> <p>Resident R1's clinical record revealed an admitted [DATE], with diagnoses of diabetes mellitus with hyperglycemia (condition where glucose [blood sugar] tends to build up in the bloodstream), colostomy (opening in the large intestine, or surgical procedure that creates one), intestinal obstruction (a gastrointestinal condition in which digested material is prevented from passing normally through the bowel), and hemorrhage of anus and rectum (blood passes from rectum or anus).</p> <p>Upon request of an abuse investigation for Resident R1, regarding an incident that occurred on 7/04/24, the facility provided information that the investigation was initiated on 7/08/24. A description of the incident revealed that on July 8, 2024, the Assistant Director of Nursing (ADON) was notified by Resident R1's family member regarding alleged abuse by a staff member toward Resident R1. The incident alleged that Registered Nurse (RN) Employee E1 had grabbed his/her wrist attempting to obtain blood sugar level and the resident felt like RN Employee E1 was trying to break their arm.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Nurse Aide Employee E2's witness statement for the incident that occurred on 7/04/24, revealed that RN Employee E1 was attempting to obtain Resident R1's blood sugar and the resident was moving her hand back and forth so the nurse grabbed her arm and told her she had to get it. Resident R1 started struggling with the RN and she was holding down her arm. NA Employee E2 had stated I told her to stop, what is wrong with you-you should leave the room and call the supervisor. The statement further indicated that NA Employee E2 had to remove RN Employee E1's hand off Resident R1's arm and the RN was upset and said f*** this job, I don't need it and threw the blood glucose testing machine that hit the table in the resident's room, called the supervisor and reported it to him/her (RN).</p> <p>Review of facility records of RN Employee E1's statement of the incident that occurred on 7/04/24, revealed - Resident's blood sugar reading Hi per Libre glucose monitor. Reported to his/her family member who requested a fingerstick confirmation. Upon entering the room to perform the fingerstick, resident became agitated and began hitting and kicking at staff. Resident swinging arm rapidly down towards overbed table and I caught his/her arm near the wrist to prevent him/her hurting himself/herself.</p> <p>Review of Resident R1's progress notes lacked evidence of an assessment of Resident's arm, physician notification, and/or any investigation of incident on 7/04/24, with RN Employee E1.</p> <p>The facility lacked evidence that a thorough investigation was immediately initiated on 7/04/24, to ensure Resident R1 and all residents were protected against potential abuse from RN Employee E1.</p> <p>During an interview on 7/24/24, at 2:35 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility was unable to provide evidence that a thorough investigation was initiated on 7/04/24, when the incident with Resident R1 and RN Employee E1 occurred, and the investigation was only initiated on 7/08/24, when Resident R1's family member notified the ADON.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		