

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  07/30/2025
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)		
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.  (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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to follow physician's orders regarding the administration of insulin for one of five residents reviewed (Resident R1). Findings include: A facility policy entitled Administering Medications dated 11/12/24, indicated that medications are administered in accordance with prescriber orders. Resident R1's clinical record revealed an admission date of 5/19/21, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), Hodgkin lymphoma (cancer of the immune system) and Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing). Resident R1's clinical record revealed a physician's order dated 3/8/25, for Insulin Lispro (a hormone that works by lowering level of glucose [sugar] in the blood) inject 3 units subcutaneously (sq - between the skin and muscle) after meals. Hold for BG (blood glucose) below 270. Resident R1's June 2025 Medication Administration Record (MAR) revealed that on 7/14/25, at 6:00 p.m. Resident R1's BG results were 212 mg/dL [milligrams/deciliter] and he/she received Insulin Lispro injection into his/her right arm when the Insulin Lispro was to be held per physician orders. During an interview on 7/29/25, at 3:12 p.m. Corporate Registered Nurse (RN) confirmed the clinical record indicated Resident R1 received his/her Insulin Lispro on 7/14/25, at 6:00 p.m. with a BG of 212 and per physician orders it was not to be given. Resident R1's clinical record revealed a physician's order dated 3/15/25, and 7/4/25, for Free Style Libre (a small sensor placed in the back of your arm so the device can continuously monitor your blood sugars) every 3 hours. A physician's order dated 5/5/25, and again 7/4/25, for Insulin Lispro inject 1 unit sq as needed for hyperglycemia (unusually high amounts of glucose are in the blood) if blood sugar (BS) is greater than 400 mg/dL and Insulin Lispro inject 2 units sq as needed for hyperglycemia if blood sugar is greater than 500 mg/dL. Resident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 12:00 a.m. with no evidence of insulin administration per physician's orders:6/13/25 413 mg/dL6/17/25 465 mg/dLResident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 3:00 a.m. with no evidence of insulin administration per physician's orders:6/17/25 435 mg/dL7/18/25 469 mg/dLResident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 6:00 a.m. with no evidence of insulin administration per physician's orders:6/17/25 500 mg/dL6/28/25 435 mg/dL7/19/25 406 mg/dL7/27/25 No resultsResident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 9:00 a.m. with no evidence of insulin administration per physician's orders:7/05/25 473 mg/dL7/06/25 436 mg/dL7/07/25 523 mg/dL7/10/25 487 mg/dL7/18/25 498 mg/dL7/19/25 444 mg/dL7/26/25 474 mg/dLResident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 12:00 p.m. with no evidence of insulin administration per physician's orders:7/07/25 416 mg/dL7/23/25 427 mg/dL7/26/25 490 mg/dLResident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 1:00 p.m. with no evidence of insulin administration per physician's orders:7/07/25 460 mg/dLResident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 6:00 p.m. with no evidence of insulin administration per physician's orders:7/06/25 469 mg/dL7/07/25 460 mg/dL7/09/25 404 mg/dL7/19/25 460 mg/dL7/20/25 418 mg/dL7/22/25 421 mg/dLResident R1's MAR revealed the following BS results for 6/13/25, through 7/29/25, at 9:00 p.m. with no evidence of insulin administration per physician's orders:7/05/25 479 mg/dL7/12/25 420 mg/dL7/15/25 459 mg/dLDuring an interview on 7/29/25, at 3:32 p.m. Corporate Registered Nurse (RN) confirmed the clinical record lacked evidence of as needed physician's order for blood sugars above 400 mg/dL and 500 mg/dL being followed stating the order may be confusing to some nurses, which may be the reason and clarification should be obtained. 28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to maintain accurate and complete documentation related to physician notification for one of five residents reviewed (Resident R17). Findings include: Review of facility policy entitled Charting and Documentation dated 11/12/24, indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's conditions and response to care. The policy further stated that documentation of procedures and treatments will include care-specific details, including notification of family, physician, or other staff, if indicated. Resident R17's clinical record revealed an admission date of 10/9/24 with diagnoses that included Alzheimer's disease (a brain disorder that destroys memory and thinking skills), diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Resident R17's clinical record revealed a physician's order dated 11/20/24, for Insulin Lispro sliding scale before meals at 7:30 a.m., 11:30 a.m., and 4:30 p.m., and bedtime at 9:00 p.m. Physician's order further indicated that if BS [blood sugar] results are 401+ [and greater] to administer 12 units of insulin and call MD (physician). Resident R17's July 2025 Medication Administration Record (MAR) revealed Resident R17's BS at 11:30 a.m. on 7/18/25, was 486 mg/dL, at 4:30 p.m. on 7/4/25, was 430 mg/dL, and at 9:00 p.m. on 7/25/25, was 422 mg/dL and on 7/28/25, was 538 mg/dL. Further review of Resident R17's clinical record lacked evidence of physician notification in accordance with physician orders. During a telephone interview on 7/30/25, at 2:50 p.m. the Nursing Home Administrator (NHA) stated the facility often will text a physician per their preferences on the supervisor's phone. NHA confirmed the supervisors phone containing text messages to the physicians are not part of the resident's permanent clinical record and the clinical record for Resident R17 lacked evidence that the physician was notified in accordance with physician's orders. 28 Pa. Code 211.5(f)(ii)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		