STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396072	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcreek Manor	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for four of eight residents reviewed for hospitalization (Residents R1, R56, R58, and Closed Record Resident CR149). Findings include: Review of a facility policy entitled Transfer or Discharge, Facility - Initiated, dated January 2026, indicated that should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: basis for the transfer or discharge, contact information of the practitioner responsible for the care of the resident, resident representative information, advance directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals, and all other information necessary to meet the resident's needs. Resident R1's clinical record revealed an admission date of 2/18/25, with diagnoses that included Parkinson's Disease (a movement disorder of the nervous system that may result in tremors, stiffness, slowing of movement, and trouble with balance that worsens over time), pneumonia (inflammation and fluid in your lungs caused by bacteria, viral, or fungal infection causing symptoms such as cough, chills, fever, and difficulty breathing), and high blood pressure. Resident R1's clinical record revealed a progress note dated 10/17/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R56's clinical record revealed an admission date of 5/10/18, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), pleural effusion (buildup of excess fluid between the layers of the pleura outside your lungs), and dementia (loss of cognitive functioning affecting a person's memory and behaviors). Resident R56's clinical record revealed a progress note dated 12/4/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R58's clinical record revealed an admission date of 2/26/21, with diagnoses that included anemia (a reduction in red blood cells resulting in symptoms such as fatigue and weakness), gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and blindness in right and left eye. Resident R58's clinical record revealed a progress note dated 10/7/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident CR149's clinical record revealed an admission date of 8/12/25, with diagnoses that included extradural and subdural abscess (serious infections that occur in the spaces surrounding the brain and spinal cord), Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), and Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications). Resident CR149's clinical record revealed a physician order dated 8/18/25, indicating to send Resident CR149 to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. During an interview on 1/22/26, at 2:09 p.m. Director of Nursing confirmed that (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396072	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcreek Manor	5535 Peach Street Erie, PA 16509

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents R1, R56, R58, and CR149's clinical records lacked evidence that necessary clinical information was communicated to the receiving health care provider. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights

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	396072	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 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 for one of 28 residents reviewed (Closed Record Resident CR149). Findings include: Review of a facility policy entitled Charting and Documentation dated January 2026 indicated All services provided to the resident, progress toward the care plan goals, or any change sin the resident's medical, physical, functional, or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The policy further sated The following information is to be documented in the resident medical record: Objective observations, Medication administration, Treatment or services performed, Changes in the resident's condition, Events, incidents or accidents involving the resident, and progress toward or changes in the care plan goals or objectives. Resident CR149's clinical record revealed an admission date of 8/12/25, with diagnoses that included extradural and subdural Abscess (serious infections that occur in the spaces surrounding the brain and spinal cord), Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), and Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications). Resident CR149's clinical record progress note dated 8/18/25, at 1:01 p.m. revealed Single lumen PICC [Peripherally Inserted Central Catheter - a long, flexible catheter inserted into a vein in the upper arm, used for prolonged intravenous access to deliver medications, fluids, and nutrition] line #5 French noted to RUE [right upper extremity]. Receiving a continuous infusion. Old dressing removed. Line noted with good blood return. Flushes easily. Good blood return. Line measures 3 centimeters from insertion site. Old, dried blood in small amount at insertion site noted. Denies pain. Flushed with 10 ml [milliliters] ns [normal saline]. Insertion site with some pink noted. New dressing applied. Taped in place. Tol [tolerated] well. A physician's order dated 8/18/25, at 1:20 p.m. revealed Send to [local hospital emergency department] due to hypotensive episodes [sudden drop in blood pressure] and persistent hypokalemia [low potassium], patient agreeable. A progress note dated 8/25/25, at 6:46 p.m. and 6:47 p.m. revealed medication orders were entered. A progress note dated 8/26/25, at 12:58 p.m. from Resident CR149's physician revealed Patient was transferred to [local hospital] on 8/18/25, due to hypotension with lightheadedness and returned to [the facility] on 8/25/25. Resident CR149's clinical record progress notes lacked evidence of Resident CR149 experiencing a hypotensive episode including lightheadedness on 8/18/25, assessment of Resident CR149, notification of his/her physician and resident representative, Resident CR149 leaving the facility, and outcome of emergency room visit. During an interview on 1/23/26, at 9:56 a.m. Regional Director of Clinical Services and Director of Nursing confirmed that Resident CR149's clinical record progress notes should be present indicating Resident CR149 experienced an episode, assessment of that episode, physician and resident representative notification, leaving the facility, and outcome of the emergency room visit and that Resident CR149's clinical record progress notes lacked evidence of this information. 28 Pa. Code 211.5(f)(ii)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services