STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675338	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Creek	1105 W Hwy 418 Silsbee, TX 77656

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview and record review the facility failed to ensure the resident had a right to personal privacy and confidentiality of his or her personal and medical records for 1 of 4 residents (Resident #1) reviewed for medical record confidentiality. The facility failed to ensure LVN A kept Resident #1's medical information confidential. LVN A left an Emergency Kit Charge Slip, dated 04/05/25, with Resident #1's name and listed the medications with administration dosage and route on the nurse station counter and in view for staff, visitors, and others. This failure could place residents at risk of their medical information being provided to unauthorized personnel, other residents, or visitors. Findings include: Record review of Resident #1's face sheet, dated 04/08/25, indicated a [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included anxiety (feeling of fear, dread, and uneasiness), heart disease, and kidney disease. During an observation of a picture provided by family member B on 04/08/25 indicated there was an Emergency Kit Charge Slip, dated 04/05/25, completed by LVN A attached to other unknown papers on the ledge of the nurse's station. Resident #1's name was visible and the Emergency Charge Slip indicated Tramadol (used to treat moderate to moderately severe pain in adults) 50 mg PO and Ativan (used to treat anxiety disorders) 0.5 mg PO. During an interview on 04/08/25 at 2:40 p.m., LVN A indicated she left Resident #1's Emergency Kit Charge Slip on the nurse's station to take back to the medication room and place it with the emergency medications. She said she did not recall leaving Resident #1's information on the nursing counter on 04/05/25. During an interview on 04/09/25 at 12:35 p.m., Family Member B said the picture of Resident #1's Emergency Kit Charge Slip was taken on 04/06/25 at 2:30 p.m. During an interview on 04/11/25 at 9:10 a.m., the RDCS said Resident #1's Emergency Kit Charge Slip, dated 04/05/25, should not have been left on the nurse counter. She said all resident records were confidential. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Resident Rights policy, dated 2002 (revised 2016), indicated 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . t. privacy and confidentiality Record review of the facility's, undated, Confidentiality of Information policy and procedure revised December 2006 indicated Policy Statement: Our facility shall treat all resident information confidentially. Policy Interpretation and Implementation: Confidentiality of Information: 1. The facility will safeguard all resident records, whether medical, financial, or social in nature, to protect the confidentiality of the information

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 8 residents (Resident #1) reviewed for pharmaceutical services. The facility failed to ensure Resident #1's Ativan (used to treat anxiety disorders) was acquired. This failure could place residents at risk of not receiving the therapeutic dosage of medication prescribed by the physician. Findings include: Record review of Resident #1's face sheet, dated 04/08/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included anxiety (feeling of fear, dread, and uneasiness), heart disease, and kidney disease. Record review of Resident #1's admission MDS assessment, dated 02/23/25, indicated she was able to make herself understood and understood others and she had moderate cognitive impairment with a BIMS-10. Record review of Resident #1's care plan, dated 03/24/25, indicated she was taking psychotropic medications as evidenced by anxiety and her medication included Ativan. Interventions included monitor and record displayed behavior or mood problems, monitor effectiveness of psychotropic medications, and review every three months for possible dose reduction. Record review of physician orders, dated 03/24/25, indicated Ativan 0.5 mg tablet, give .25 mg PO, break 0.5 mg tablet in half. The related diagnosis was anxiety disorder. Record review of progress note, dated 03/24/25 at 10:11 p.m., completed by LVN C, indicated Resident #1 had increased agitation and irritation. Resident #1 was hollering in the hallway and attempted multiple times to call family members. NP D was notified. New orders: Ativan 0.25 mg Q 12 hours PRN. Record review of the facility's Emergency Kit Usage Log, dated 03/24/25 at 5:00 p.m., completed by LVN C indicated she obtained 0.5 mg Ativan for Resident #1. Record review of LVN A's statement, dated 04/10/25, indicated a telephone order was received from NP D for Resident #1's, Ativan 0.5 mg give 1/2 tab Q 12 hours for increased agitation. The order was put in the computer and faxed to the pharmacy to be filled. The RP and family made aware. The medication was taken from the Emergency Kit with the notification slip of usage also faxed to the pharmacy. Record review of Resident #1's MAR dated 03/24/25 indicated LVN A did not document PRN Ativan administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/08/25 at 2:40 p.m., LVN A said she obtained Resident #1's Ativan from the facility's Emergency kit because there was none on the medication cart. During an interview on 04/09/25 at 10:49 a.m., LVN C said Resident #1 was hollering for her family member and agitated on 03/24/25. She said Resident #1 was trying to call family and no one was answering the phone. She said she obtained an order for Ativan .25 mg PRN every 12 hours due to increased agitation. She said there was .5 mg Ativan in the emergency kit. She said she obtained the .5 mg tab and halved it and administered .25 to Resident #1. She said she advised the next nurse on shift, LVN A, to make sure the order was sent to the pharmacy. During an interview on 04/09/25 at 1:19 p.m., NP C said she received a call from LVN A regarding Resident #1's increased agitation. She said she ordered .25 mg every 12 hours PRN. She said she was not aware the facility did not receive the medication from the pharmacy. She said she was not aware the pharmacy did not have the required prescription. During an interview on 04/11/25 at 9:00 a.m., the RDCS said all medication orders and faxes should be in the medication binder until the medication was delivered. She said the night charge nurse (LVN C) should reconcile medications and follow-up if the medication was not received. She said the charge nurse and DON should follow up and ensure all the orders were received. She said the pharmacy received the fax order for Resident #1's Ativan but they did not receive the prescription from the physician. She said she was not able to locate the order or fax confirmation in the facility's medication binder. She said residents were at risk of not receiving medications as needed if the facility did not follow up to ensure all medications were received as required. Record review of the facility's Medication Ordering Procedures, dated 2022, indicated . Reminder: Orders for controlled substances require a written prescription from the physician .The DON and the Pharmacy must be notified immediately of any mediations not received from the Pharmacy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical record maintained for each resident were complete and accurately documented for 1 of 8 residents (Resident #1) reviewed for resident records. The facility failed to ensure LVN A documented a progress note or nurse note of Resident #1's increased agitation on 04/05/25. This failure could place residents at risk for delayed care and appropriate interventions. Findings include: Record review of Resident #1's face sheet, dated 04/08/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included anxiety disorder (feeling of fear, dread, and uneasiness), heart disease, and kidney disease. Record review of Resident #1's admission MDS assessment, dated 02/23/25, indicated she was able to make herself understood and understood others and she had moderate cognitive impairment indicated with a BIMS-10. Record review of Resident #1's care plan, dated 03/24/25, indicated she was taking psychotropic medications as evidenced by anxiety and her medication included Ativan. Interventions included monitor and record displayed behavior or mood problems, monitor effectiveness of psychotropic medications, and review every three months for possible dose reduction. Record review of Resident #1's physician orders, dated 03/24/25, indicated Ativan 0.5 mg tablet, give .25 mg PO, break 0.5 mg tablet in half. The diagnosis was anxiety disorder. Record review of Resident #1's MAR, dated 04/05/25, completed by LVN A, indicated she was administered half of 0.5 mg Ativan (.25 mg) at 11:07 p.m. Record review of Resident #1's EHR indicated there was no progress note or nurse note dated 04/05/25. There was no documentation of Resident #1's increased agitation or administration of .25 mg Ativan. During an interview on 04/08/25 at 2:40 p.m., LVN A said she thought she documented a progress note in Resident #1's EHR on 04/05/25 for the increased agitation and anxiety. During an interview on 04/11/25 at 9:00 a.m., the RDCS said nursing staff were supposed to document by exception. She said that included behaviors and change in condition in resident charts. She said residents were at risk for delayed care if the proper documentation was not completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Charting and Documentation policy, dated 2001 (revised July 2017), indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record . 2. The following information is to be documented in the resident medical record: a. Objective observations; 2. Medications administered, Treatments or services performed: d. Changed in the resident's condition; Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives .7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided care; c. the assessment data and .or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting.