

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Mill Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on interview and record review, the facility failed to accurately submit a PL1 (PASRR Level 1 Screening) screening when a resident admitted with a diagnosis of Mental Illness, Intellectual Disability or Developmental Disability for 1 of 5 residents reviewed for PASRR screenings. (Resident #7) The facility failed to submit a new PL1 screening when Resident #3 was diagnosed on [DATE] with Major Depressive Disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily living) during her stay. This failure could place residents at risk of not receiving specialized services. Findings included: Record review of Resident #7's face sheet dated 09/16/24 was an [AGE] year-old-female admitted [DATE] with diagnoses of generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), major depressive disorder. Record review of Resident #7's PASRR Level 1 Screening, dated 12/29/23, indicated Resident #7 was negative for mental illness, intellectual disability, and developmental disability and negative for dementia as the primary diagnosis. There was no PASRR Level II Screening or Form 1012 (Mental Illness/Dementia Resident Review) found in the clinical record from the resident's admission on 12/29/23 to 09/17/24. Record review of Resident #7's Psychiatric Initial Assessment, dated 02/12/24 indicated a diagnosis of major depressive disorder, recurrent, moderate. Record review of Resident #7's annual MDS dated [DATE] indicated not PASRR positive and had a BIMS score of 8 indicating moderately impaired of cognition and had a diagnosis of major depressive disorder. Record review of Resident #7's quarterly MDS dated [DATE] with a BIMS score of 10 indicated moderately intact cognition with a diagnosis of major depressive disorder. (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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's physician orders dated 09/18/24 indicated she was prescribed bupropion HCL 100 mgs every day for major depressive disorder with a start date of 05/15/24 and paroxetine 40 mg every day at bedtime for major depressive disorder with a start date of 07/03/24 and mirtazapine 15 mgs every day at bedtime for major depressive disorder with start date of 09/17/24. Record review of Resident #7's MAR dated 09/17/24, indicated she received bupropion HCL 100 mgs every day for major depressive disorder with a start date of 05/15/24 and paroxetine 40 mg every day at bedtime for major depressive disorder with a start date of 07/03/24 and mirtazapine 15 mgs every day at bedtime for major depressive disorder with start date of 09/17/24. Record review of Resident #7's care plan printed on 09/16/24 indicated Resident #7 received psychotropic medication for depression and anxiety with a goal to not experience adverse side effects over the next 90 days. During an interview on 09/17/24 at 1:20 p.m., the MDS nurse said she started working at the facility at the end of January. She said she was now responsible for all PASRR forms at the facility. She said the previous MDS nurse documented the PL1 as negative. The MDS nurse said she was in-serviced on PASRR form completion with October 2023 being the most recent. The MDS nurse said she had no back up or anyone to double check PASRR forms behind her. The MDS nurse said the risk of a PL1 form being incorrect was a resident could miss out on services, help, and support. During an interview on 09/17/24 at 1:32 p.m., the DON said the MDS nurse was responsible for all PASRR forms in the facility and was educated on correctly completing PASRR forms. She said Resident #7 's PL1 was possibly completed incorrectly by the previous MDS nurse. She said the risk of PASRR forms completed incorrectly was a resident could miss out on deserved services. The DON said her expectation was all PASRR forms completed accurately and timely so the resident could get the services they needed. During an interview on 09/17/24 at 1:39 p.m., the Administrator said the MDS nurse was responsible for all PASRR forms in the facility and was educated on correctly completing PASRR forms. She said the Regional Care Coordinator was the MDS nurses back up. She said Resident #7 's PL1 was possibly overlooked during the change in MDS coordinators. The Administrator said the risk of PASRR forms completed incorrectly was a resident could miss out on deserved services. The Administrator said her expectation was all PASRR forms completed accurately and timely. She said the facility followed the RAI for the PASRR policy. During an interview on 09/17/24 at 2:35 p.m., the Regional Care Coordinator said the MDS nurse and resident's family were responsible for completing the PL 1 when the resident admitted from home as Resident #7 did. She said the IDT (inter-disciplinary team) reviewed the admission paperwork and on receiving new diagnoses and if the DON noted a required diagnosis, the PL1 would be changed. She said the MDS nurse was educated on completion PL1s accurately and to let the local authority come in and make the decision if the resident qualified for services. The Regional Care Coordinator said when the psychiatric group that contracted with the facility reviewed residents at the facility and added diagnoses the paperwork was not submitted timely. She said the risk of a PL1 form completed incorrectly was if the resident should be positive the resident could get more assistance depending on needs. She said the local authority will come out to the facility on [DATE] and make Resident #7 PASRR negative . (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the October 2023 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual titled, A1500: Preadmission Screening and Resident Review (PASRR) Item Rationale Health-related Quality of Life indicated . o All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions o Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review the facility failed to ensure residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents reviewed for dialysis. (Resident #36) * The facility did not have ongoing communication with the dialysis facility regarding dialysis care and services for Resident #36. * The facility did not have ongoing assessment of Resident #36's condition and monitoring for complications after dialysis treatments received at a certified dialysis facility. This failure could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of Resident #36's face sheet dated 09/30/2024 indicated he was a [AGE] year-old male admitted on [DATE] with diagnoses of end stage renal disease (occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state) and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of Resident #36's physician orders for September 2024 indicated an order dated 02/12/24 for Dialysis-Post [treatment] frequency. Notes: Upon return, enter Dialysis Treatment Information received from Dialysis Center onto the Dialysis Communication Record. Complete the Post Dialysis Assessment Section Record review of the current MDS dated [DATE] indicated Resident #36 was cognitively intact with a BIMS score of 13 out of 15 (13-15/cognitively intact, 8-12/moderately impaired, 0-7 severely impaired) and he received dialysis while a resident. During an observation and interview on 09/16/24 at 09:00 a.m. Resident #36 was in bed. He was clean, neat, and had no odors. He said he was doing fine and had no issues. He said he went to dialysis on Mondays, Wednesdays, and Fridays if he felt like going. He said the nurse sent him with a sheet for dialysis to fill out and bring back. Record review of a blank Dialysis Communication Record used by the facility: Pre-dialysis Information (Nursing Facility Nurse) section indicated: Medication given in the last 6 hours: Vomiting: Time of last meal: (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Contact person for today: Dialysis Treatment (Dialysis Nurse) section indicated: Medications given during/after treatment: Pre-Dialysis: weight; temperature, pulse, respirations, and blood pressure. Post-Dialysis: weight; temperature, pulse, respirations, and blood pressure. Special instructions or comments Name of Dialysis Nurse Post-Dialysis Assessment (Nursing Facility Nurse) section indicated: Bruit (whooshing sound)/ thrill (buzz sound of blood flowing) present Signs of infection at graft/shunt Bleeding at graft/shunt site after treatment Changes in skin integrity Blood pressure, pulse, Respirations, Temperature Nurse signature and date Record review of the Dialysis Communication Forms for the month of July 2024 (in the EMR and hard copies provided by the facility) for Resident #36 indicated: * 07/02-Dialysis Treatment (Dialysis Nurse) section and Post Dialysis Assessment by the facility nurse were blank. * 07/04-Dialysis Treatment (Dialysis Nurse) section and Post Dialysis Assessment by the facility nurse were blank. * 07/08-there was no Dialysis Communication Record. * 07/10-there was no Dialysis Communication Record. * 07/12-there was no Dialysis Communication Record. * 07/15-there was no Dialysis Communication Record. * 07/17-Dialysis Treatment (Dialysis Nurse) section and Post Dialysis Assessment by the facility nurse were blank. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 07/29-Post Dialysis Assessment by the facility nurse were blank. * 07/31-Dialysis Treatment (Dialysis Nurse) section and Post Dialysis Assessment by the facility nurse were blank. Record review of the Clinical Notes in the EMR for Resident #36 indicated: * 07/08-there was no documentation; * 07/10-there was no documentation; * 07/12-there was no documentation; and * 07/15-there was no documentation. During an interview on 09/18/24 at 09:12 a.m. the DON said when she started there was an issue with nursing documentation, so she did a PIP to address the issue. Record review of a Performance Improvement Plan dated 08/08/24 indicated: Problem Area Identified: Lack of consistent nursing assessments documentation Baseline: 100% daily Allowable Deviation:1 Month Changes Implemented to reach Baseline: 1. In-service all nurses on the timely/complete documentation. 2. Educate all nurses on correct assessments due to situation. 3. DON/ADON to review/monitor nursing assessments daily. 4. Educate nursing staff on where to locate all nursing assessments/documentation. Impact of Change: New PIP Successful implementation of changes noted above. Baseline attained on (Date):____. This was not marked on the form. Implemented change did not reach baseline. This was not marked on the form. Continue change for 30 more days to allow additional time for staff to comply with new system. New changes or modifications will be implemented and tested for 30 days to bring measured activity to baseline. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subcommittee will report to QAPI Committee every month regarding movement towards baseline. This was marked on the form. Record review of the Dialysis Communication Records for the month of August 2024 (in the EMR and hard copies provided by the facility) for Resident #36 indicated: 08/14-Post Dialysis Assessment by the facility nurse had no assessment of bruit/thrill, signs of infection at graft/shunt, bleeding at graft/shunt site after treatment, or changes in skin integrity. 08/19-Post Dialysis Assessment by the facility nurse had no assessment of bruit/thrill, signs of infection at graft/shunt, bleeding at graft/shunt site after treatment, or changes in skin integrity. 08/26-Post Dialysis Assessment by the facility nurse had no assessment of bruit/thrill, signs of infection at graft/shunt, bleeding at graft/shunt site after treatment, or changes in skin integrity. 08/28-Dialysis Treatment (Dialysis Nurse) section and Post Dialysis Assessment by the facility nurse were blank. 08/30-Post Dialysis Assessment by the facility nurse was blank Record review of the Dialysis Communication Records for the month of September 2024 (in the EMR and hard copies provided by the facility) for Resident #36 indicated: 09/09-Dialysis Treatment (Dialysis Nurse) section was blank 09/11-there was no Dialysis Communication Record 09/13-Dialysis Treatment (Dialysis Nurse) section was blank and Post Dialysis Assessment by the facility nurse had no assessment of bruit/thrill, signs of infection at graft/shunt, bleeding at graft/shunt site after treatment, or changes in skin integrity. Record review of the Clinical Notes in the EMR for Resident #36 indicated on 09/11 there was no documentation. During an interview on 09/18/24 at 09:16 a.m. LVN D said she worked 6a-2p shift when Resident #36 goes to dialysis and fills out the EMR form, prints it out, and sends with him to dialysis. She said he returned from dialysis on the 2p-10p shift the nurse on the shift was to check the communication form to ensure the dialysis facility provided the information regarding the resident while at the dialysis center. She said the 2p-10p nurse was responsible for obtaining the information if it was not on the communication form and to conduct an assessment on the resident. She said if the information from the dialysis center was not there then the nurse would not know if they needed to follow up on anything. She said if the assessment was not done What is the risk to the resident due to this failure? How is this monitored to ensure communication and assessments are being completed? Who is responsible for ensuring this is being completed? (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 10:45 a.m. the DON said she expected the nurses to do the follow up when a dialysis resident returns from the dialysis center. She said the dialysis resident could have complications from the dialysis procedure and nurse not be aware because there was no information from the dialysis center about what was done, or not doing a complete assessment when returning from the dialysis center. During an interview on 09/18/24 at 02:48 p.m. the Interim Administrator indicated she expected communication between the facility and the dialysis centers regarding the residents who required dialysis treatment or there could be missed information. Record review of a Dialysis Protocols policy revised February 2024 indicated The [company name] Community will send a Dialysis Communication Record ([NAME] form FCAN 620) to the dialysis facility upon each dialysis visit. The [company name] Patient will complete the top of the form, entitled Nursing Home Nurses and provide to the Patient prior to exiting the facility The dialysis facility should be encouraged to complete the middle section of the Dialysis Communication Record and return to the [company name] Community. The [company name] Community nurse will complete the Post Dialysis Assessment section of the Dialysis Communication Record and file the form in the binder		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional principles in 1 of 3 medication carts reviewed. (Hall 200 medication cart for Residents Rooms 100 - 112B) in that: A multi-dose vial of Novolin R insulin (used to lower blood sugar) with an open date of [DATE], had been expired for 59 days. A multi-dose vial of Lantus insulin (used to lower blood sugar) with an open date of [DATE], had been expired for 69 days. This failure could place residents at risk for accidents, hazards, and not receiving therapeutic effects of medication. The findings included: Record review of Resident #24's face sheet dated [DATE] indicated a [AGE] year-old female admitted [DATE] with diagnoses included: cerebral infarction (stroke usually called by blood clots) and type 2 diabetes mellitus (trouble controlling blood sugar). Record review of Resident #24's quarterly MDS assessment with an ARD of [DATE] indicated the resident had a BIMS score of 11 indicating the resident was moderately impaired of cognition. The assessment indicated she was diagnosed with depression and stroke and received antidepressant medication during the review period. Record review of Resident #24's physician order, dated [DATE], indicated she was prescribed Novolin R Regular U- 100 Insulin 100 unit/ml inject solution (,d+[DATE] units) subcutaneous. Inject as per sliding scale: if ,d+[DATE] = 0 unit, ,d+[DATE] = 2 units, ,d+[DATE] = 4 units, ,d+[DATE] = 6 units, ,d+[DATE] = 8 units, ,d+[DATE] = 10 units, 401 or greater = 12 units and notify physician for type 2 diabetes mellitus. Resident #24 was prescribed Lantus U-100 Insulin 100 unit/ml solution (5units) subcutaneous, hold if blood sugar was less than 100 with a start date of [DATE] for type 2 diabetes mellitus. Record review of Resident #7's care plan updated [DATE] indicated she was diabetic and received routine insulin and insulin per sliding scale. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 12:25 p.m., during a review of 1 of 2 Hall 100 medication carts, the medication cart for Rooms 100 - 112B with LVN E, revealed two insulin vials in use beyond the recommended time frame of use after the vials were opened. One 10 ml vial about ,d+[DATE] full of Novolin R insulin with an expiration date of [DATE] and an attached sticker labeled with Resident #24 name and dated with an open date of [DATE] in black maker was observed. Also observed was one 10 ml vial about , d+[DATE]'s full of Lantus insulin with an expiration date of [DATE] and an attached sticker labeled with Resident #24's name and dated with an open date of [DATE]. During an interview on [DATE] at 12:25 p.m., LVN E said she had been giving medication from Hall 100 cart Rooms 100 through room [ROOM NUMBER]B. She said Resident #24 transferred from Hall 200 on the 2 pm-10 pm shift on [DATE]. LVN E said she had not given Resident #24's Novolin R insulin or Lantus insulin. She said both insulin vials should have been removed from the medication cart and put in the drug destruction box after being opened 30 days. LVN E said she always checked dates before administrating medication. She said the nurses were responsible for monitoring the medication carts daily for expired medication and insulin vials over the recommended time frame of use after the open date of 28 days for Lantus and 42 days for Novolin R. She said it may have been missed being removed from the cart due to Resident #24 transferred from Hall 200 to Hall 100 on the evening shift. LVN E said she was educated on insulin and monitoring for expiration and open dates. She said the DON double checked the carts. LVN E said the risk of insulin vials in use beyond the recommended time frame of use after vial opened was the medication may be not as effective. During an interview on [DATE] at 12:45 p.m., the DON said the nurses were responsible for checking the medication carts daily on for expired meds and insulin vials in use beyond the recommended time frame of use after the vial was opened and she was the back up and double checked the carts. The DON said she checked all the insulin vials on the medication carts yesterday and did not see Resident #24's insulin vials with open dates in July. She said they should have been removed. She said the insulin vials were possibly overlooked when the resident was transferred to a different hall yesterday. The DON said all the nurses were educated on insulin administration and disposal dates on [DATE]. She said the risk of insulin vials in use beyond the recommended time frame of use after the vial was opened was potential adverse reactions. The DON said her expectation was all insulins checked daily for use beyond the recommended time frame of use after the vial was opened and expiration dates, stored properly and given per policy. During an interview on [DATE] at 1:04 p.m., the Administrator said the floor nurse was responsible, and the DON and pharmacy consultant were a double check for expired medication on medication carts with the county hospital making checks monthly for insulin vials in use beyond the recommended time frame of use after the vial was opened. She said the insulin vials may have been overlooked. She said the nurses were in-serviced on insulin and open dates. She said the risk of insulin vials in use beyond the recommended time frame of use after the vial was opened was may potentially be not as effective. The Administrator said her expectation was insulin vials checked and maintained properly, expired or vials in use beyond the recommended time frame of use after the vial was opened be removed. Record review of an undated form provided by the facility titled, Insulin discard Time Frames, indicated, .28 days: . Lantus . 42 days: . Novolin R . (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a web site titled, Novolin R injection label (fda.gov) Accessed on [DATE], indicated, . treatment of diabetes mellitus . Unopened and opened (In use) Novolin R vials must be discarded 42 days after they are first kept out of the refrigerator, even if they still contain Novolin R insulin . Record review of a web site titled, Long Acting Insulin For Diabetes Lantus(R) (insulin glargine injection) 100 Units/mL accessed on [DATE], indicated, . LANTUS is a long-acting man-made-insulin used to control high blood sugar in adults and children with diabetes mellitus . storage instructions . The Lantus vials you are using should be thrown away after 28 days, even if it still has insulin left in it.		

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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** 30664 Based on observation, interview, and record review the facility failed to ensure in accordance with accepted professional standards and practices, the facility to maintain medical records on each resident that are accurately documented for 1 of 13 residents review for clinical records. (Resident #36) * The facility did not have an accurate physician order for Resident #36's dialysis days. * The facility did not have accurate information on the TAR for Resident #36. This failure could place residents at risk of incomplete clinical records and a decrease in staff knowledge regarding resident care. Findings included: Record review of Resident #36's face sheet dated 09/30/2024 indicated he was a [AGE] year-old male admitted on [DATE] with diagnoses of end stage renal disease (occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state) and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of Resident #36's physician orders for September 2024 indicated an order dated 02/12/24 Dialysis - Pre [treatment] Frequency Notes: DIALYSIS on Tuesday, Thursday, and Saturday Record review of Resident #36's TARs for July 2024 indicated staff documented information for his dialysis on Tuesday, Thursday, and Saturday. Record review of Resident #36's TARs for August 2024 indicated staff documented information for his dialysis on Tuesday, Thursday, and Saturday. Record review of Resident #36's TARs for September 2024 indicated staff documented information for his dialysis on Tuesday, Thursday, and Saturday. Record review of the current MDS dated [DATE] indicated Resident #36 was cognitively intact with a BIMS score of 13 out of 15 (13-15/cognitively intact, 8-12/moderately impaired, 0-7 severely impaired) and he received dialysis while a resident. During an observation and interview on 09/16/24 at 09:00 a.m. Resident #36 was in bed. He was clean, neat, and had no odors. He said he was doing fine and had no issues. He said he went to dialysis on Mondays, Wednesdays, and Fridays if he felt like going. He said the nurse sent him with a sheet for dialysis to fill out and bring back. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Mill Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 01:15 p.m. LVN D said Resident #36 received dialysis services on Monday, Wednesday, and Friday and those were the days she sent him. During an interview and record review on 09/18/24 at 01:25 p.m. LVN D and the ADON said Resident #36 received dialysis services on Monday, Wednesday, and Friday. They acknowledged the July, August, and September 2024 TARs indicated Resident #36 received dialysis on Tuesday, Thursday, and Saturday and the nurses were documenting their pre and post dialysis assessments on Tuesday, Thursday, and Saturday. During an interview on 09/18/24 at 01:35 p.m. the DON said Resident #36 received dialysis on Monday, Wednesday, and Friday. She acknowledged the documentation being incorrect on the TARs. During an interview on 09/18/24 at 01:57 p.m. the DON and ADON acknowledged the physician orders indicated Resident #36 was to receive dialysis on Tuesday, Thursday, and Saturday. They said Resident #36 had dialysis on Mondays, Wednesdays, and Fridays. They said the order was not correct. They said it was the administrative nursing responsibility to audit charts for accuracy. During an interview on 09/18/24 at 02:48 p.m. the Interim Administrator said she expected the clinical records to be accurate. She said it was the administrative nursing responsibility to audit charts for accuracy. She indicated residents could be provided the incorrect care if the information was not accurate. Record review of a Charting and Documentation policy revised July 2017 indicated Policy Interpretation and Implementation:1. Documentation in the medical record may be electronic, manual or a combination .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate		