

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/10/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 (Resident #2) residents reviewed for quality of care. 1. The facility failed to identify and treat Resident #2's three scabbed skin tears on left 2nd toe, 3rd toe, 4th toe. 2. The facility failed to ensure Resident #2 (diabetic) had orders in place to treat 3 scabbed skin tears on left 2nd toe, 3rd toe, 4th toe. These failures could place residents at risk of not receiving appropriate care, or treatment, leading to diabetic ulcers, infection, and a decreased quality of life. Findings included: Record review of Resident #2's face sheet, dated 12/08/2025 indicated she is a [AGE] year-old female that was re-admitted to the facility 11/09/2025. Diagnoses included type 2 diabetes, periprosthetic fracture around internal prosthetic left knee joint (a fracture around a knee joint replacement), weakness, candidiasis of skin and nails (fungal growth on nails and skin), lack of coordination, edema (swelling of the body). Record review of Resident #2's MDS, dated [DATE] indicated she had a BIMS score of 15, indicating she was cognitively intact. In section N - medications- Resident #2 was taking insulin injections that control her blood sugar. Section M- skin conditions indicated clinical assessments were needed to determine her risk for pressure ulcers and risk for injury. Resident #2 was at risk for developing pressure ulcers and injuries. Resident #2 had no unhealed pressure ulcers or ulcer/ injuries at readmission, diabetic foot ulcers, other lesions on the foot skin tears, or moisture associated skin damage. (11/09/2025.) Record review of Resident #2's care plan, dated 11/06/2025, indicated 3 scabbed skin tears on left 2nd toe- 0.50 cm 3rd toe- 1.20 cm x 1.00 cm, x 0.50 cm, left 4th toe- 1.30 cm x 0.40 cm had not been care planned nor were there interventions listed that addressed what kind of wound care treatment was needed. Resident #2's care plan stated The resident has Diabetes Mellitus and is currently receiving Insulin lispro, glargine. Interventions: Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Record review of facility Incidents and accidents for the past 6 months indicated Resident #2 was not listed regarding her 3 scabbed skin tears on left 2nd toe, 3rd toe, 4th toe. Record review of Resident #2's orders for November and December 2025 indicated there were no orders for treatment for her left 2nd toe, 3rd toe, 4th toe. Record review of Resident #2's weekly head- to- toe assessment dated [DATE] at 7:19 a.m., indicated her skin was clean and did not indicate that she had any abrasions or skin tears on her left 2nd toe, 3rd toe, 4th toe. Record review of Resident #2's nursing skilled assessment dated [DATE] at 11:43 a.m., did not indicate that she had any abrasions or skin tears on her left 2nd toe, 3rd toe, 4th toe. Record review of Resident #2's progress notes from 11/8/2025-12/8/2025 did not indicate that she had any abrasions or skin tears on her left 2nd toe, 3rd toe, 4th toe. During an observation on 12/08/2025 at 10:00 a.m., the surveyor identified 3 scabbed skin tears to Resident #2's 2nd, 3rd, and 4th toes on left foot. During an interview on 12/8/2025 at 10:38 a.m., with Resident #2 she said she was not aware that there was anything on her toes. She said no one had done wound care on her feet. During observation and interview on 12/9/2025 at 10:55 a.m., with the Wound Care Nurse, she confirmed with surveyor the 3 scabbed skin tears on Resident #2's left 2nd toe, 3rd toe, 4th toe. During an interview with LVN B on 12/09/2025 at (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have had orders that addressed the care needed for her 3 toes on her left foot. She said not identifying skin issues on Resident #2 accurately could potentially cause residents to not receive needed care or services. During an interview with CNA E on 12/9/2025 at 3:42 p.m., she said she was responsible for showering Resident #2 on the evening shift. She said she had showered and washed Resident #2's toes on 12/6/2025 and had not noticed any abrasions or skin tears on her toes. Record review of facility policy titled Patient Care Management System 1 dated July 2022 indicated: In part-Skin: 2. The Treatment Nurse or Nurse Manager designee will complete a head-to-toe assessment and document in the EMR to validate the findings of the initial skin assessment. Head-to-toe assessments must be completed weekly and prior to discharge/transfer of a Patient.3. A Braden Scale will be completed the day of admission (including readmission), once weekly for a minimum of four weeks, and quarterly thereafter. A Braden Scale will also be completed upon each significant change in a Patient's condition. The Braden Scale will be used in conjunction with clinical judgement and review of other risk factors. The total score is not relied upon alone in determining a Patient's pressure ulcer risk.4. Any newly identified wounds will be addressed by the Treatment Nurse or Charge Nurse to include assessment and documentation of the skin site and initiate appropriate clinical interventions. Notify Patient's Representative and Medical Provider of any new or change in existing wound(s) and document in EMR.5. A Wound Assessment will be completed by the Treatment Nurse or Charge Nurse and a narrative of each site will be documented weekly for any pressure injury and non-pressure skin condition, including but not limited to Arterial Ulcers, Diabetic Neuropathy Ulcers, Venous Insufficiency Ulcers, Bruises, Skin Tears, and Surgical Wounds. Wound measurements will be in centimeters.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 halls. 1. The facility failed to ensure CNA A did not handle soiled linen without gloves. 2. The facility failed to ensure CNA A used hand hygiene after she disposed of soiled linens. 3. The facility failed to ensure CNA A used hand hygiene between glove changes. 4. The facility failed to ensure feces were not on the floor. 5. The facility failed to ensure CNA B performed proper hand hygiene while entering and exiting residents' room on hall 200 while providing ice and water for hydration services. 6. The facility failed to ensure CNA B did not touch hydration cart ice scoop to the inside of resident's cup while providing ice and water for hydration services. 7. The facility failed to ensure CNA B discarded Resident #2's used straw that contained pink and dark brown colored debris. 8. The facility failed to ensure CNA B did not bring residents used cup into the soiled utility room and brought it back to residents while providing ice and water for hydration services. These failures could place residents at risk of the spread of infection. Findings include: During an observation of hall 200 on 12/08/2025 at 9:00 a.m., CNA A disposed of soiled linens without gloves on. She did not use hand hygiene after soiled linens were disposed of. CNA A put on gloves to adjust Resident #33's brief and clothing. She removed her gloves and put on new ones without using hand hygiene between glove change. During an observation on 12/09/2025 at 11:00 a.m., there was approximately a dime sized light brown feces located on the floor of room [ROOM NUMBER]. During an observation on 12/10/2025 at 10:28 a.m., CNA B did not wash or sanitize his hands prior to entering/exiting rooms or handling the hydration cart ice scoop, new cups, lids, straws, old used cups and residents personal used insulated cups for the rooms on Hall 200. CNA B entered room [ROOM NUMBER], walked to both residents' bedside tables and touched them with ungloved hands while picking up both residents' insulted drinking cups and brought them to the rolling ice cart. CNA B touched the hydration cart ice scoop to residents' used insulated cups while filling them with ice. She went into Resident #2's room (who was on enhanced barrier precautions), came out with a bag of trash in her left hand and resident's used insulated cup in her right hand. CNA B had Resident #2's used insulated cup inside the soiled utility room while she disposed of trash. Resident #2's straw had pink and dark brown debris inside it. She took Resident #2's cup out of the soiled utility room, walked to the rolling ice chest, grabbed the ice scoop and touched the hydration cart ice scoop to her cup while she was putting ice in it. CNA B brought Resident #2's same used cup to her. The surveyor intervened before Resident #2 drank out of the cup. A new cup of ice water was given to Resident #2. During an interview on 12/08/2025 at 10:00 a.m. with CNA A, she said she should have had gloves on when she disposed of soiled linens that were used during a bed bath. CNA A said she should have used hand hygiene before putting on gloves and after taking them off. She said these failures could lead to a spread of infection to residents. She said she has been checked off on handwashing and had received infection control training when she was hired and annually. During an interview on 12/09/2025 at 12:22 p.m. with CNA B, she said she should have washed or sanitized her hands before entering and after exiting residents' room on hall 200 while providing ice and water. She said she was responsible for providing Hall 200 hydration services and was supposed to perform hand hygiene before and after entering residents' rooms. She said she should not have touched the hydration cart ice scoop to the inside of the resident's cup while providing ice and water. CNA B said she did not know why she did not perform hand hygiene. She said she should not have brought Resident #2's used cup into the soiled utility room and brought it back to her. She said the risks associated with these failures were potentially passing germs to residents. She said she has been checked off on handwashing and had received infection control training when she was hired and annually. During an interview on 12/09/2025 at 1:20 p.m. with the DON, she said (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she expected staff to use hand hygiene according to policy, handle soiled linen with gloves, and staff should get residents a new cup when the sanitation is compromised. She said staff should sanitize prior to entering a resident's room and between rooms. She said feces should not be on the floor, instead it should be properly disposed of to prevent cross contamination and infection control. During an interview on 12/09/2025 at 1:30 p.m. with the Regional Director of Clinical Services, she said staff should use hand hygiene according to policy, handle soiled linen with gloves, and staff should get residents a new cup when the sanitation is compromised. She said staff should sanitize prior to entering a resident's room and between rooms. She said feces should not be on the floor, instead it should be properly disposed of. She said following facility policy on infection control helps to potentially protect residents from cross contamination. During an interview on 12/09/25 at 1:40 p.m. with the Administrator, she said staff had been educated on hydration services and ways to prevent cross contamination. She said feces should not be on the floor, staff should properly dispose of feces to prevent the spread of infection. She said by staff following facility policy on infection control helps to potentially protect residents from infection and cross contamination. The Administrator said she expects staff to follow facility policy regarding hand hygiene, sanitizing, and infection control. She said staff should get a new cup for residents when contaminated to reduce the risk of cross contamination. During an interview 12/10/25 at 12:45 p.m. with LVN C, she said she was the charge nurse for hall 200 and supervised the CNAs working on her hall. She said her expectations for CNAs were to take care of the residents, use gloves while caring for residents and wash hands when they enter a resident's room during care and after care. She said she has educated her aides on performing hand hygiene before entering a resident's room and after leaving a resident's room. She said the risk of staff not performing hand hygiene and infection control was the potential to spread germs and infection. LVN C said she was trained and had a skill check-off on hand hygiene. Record review of facility policy titled Hand Hygiene not dated indicated, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand hygiene Is a general term for cleaning your hands by hand washing with soap and water where the use of an antiseptic can rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique comma consistent with accepted standards of practice. 2. 6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of facility corporate dated October 2010 titled Serving Drinking Water indicated, Equipment and Supplies and Steps in the Procedure Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure. 1. Movable serving cart; 2. Ice chest and cover; 3. Ice; 4. Scoop; 5. Water pitcher and cup; 6. Flexible straw; 7. Paper towels; and 8. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure: 1. Fill the ice chest with ice. Cover the chest. 2. Roll the cart to the outside entrance of the resident's room. 3. Go to the resident's bedside stand and pick up the water pitcher. 4. Take the water pitcher into the bathroom. Empty the contents into the commode. 5. Rinse the water pitcher with tap water. Pour the water down the sink. 6. Fill the water pitcher one-half full with tap water. 7. Unless the resident is in isolation, take the water pitcher to the ice cart outside the room. Fill the pitcher with ice. Do not let the ice scoop touch the water pitcher. 8. Return the water pitcher to the resident's bedside stand. 9. Wipe the bedside stand with a clean paper towel. Discard used paper cups, paper towels and other disposable items into designated container. 10. Offer the resident a fresh cup of water. 11. Place the water pitcher and cup within easy reach of the resident. Place flexible straws next to the water pitcher. 12. Repeat steps 2 through 11 until the procedure has been completed for each of your assigned residents. Wash your hands. Record review of CDC Clinical Safety: Hand Hygiene for Healthcare Workers recommendations dated 2/27/24, indicated, Protect yourself and your patients from deadly germs by cleaning your hands. All healthcare personnel should understand how (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to care for and clean their hands. Why it matters. Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with: Handwashing with water and soap (e.g., plain soap or with an antiseptic); antiseptic hand rub (alcohol-based foam or gel hand sanitizer); and surgical hand antisepsis. Cleaning your hands reduces: the potential spread of deadly germs to patients; the spread of germs, including those resistant to antibiotics; and the risk of healthcare personnel colonization or infection caused by germs received from the patient.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure all residents had the right to formulate an advance directive for 2 of 10 residents (Resident #21 & #31) reviewed for advance directives. The facility failed to ensure Resident #21 who was listed as DNR (Do Not Resuscitate) had a valid Out-of-Hospital Do Not Resuscitate (OOH-DNR) form that was not missing required information and did not have the Witness sign and date after the qualified relative signature date. The facility failed to ensure Resident #31 who was listed as DNR had a valid Out-of-Hospital Do Not Resuscitate form that did not have scribble to correct the printed name twice. This failure could place residents at risk of not having their end-of-life wishes honored and incomplete records. Findings included: Record Review of Resident #21's face sheet, dated [DATE], indicated an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included: hypertension (high blood pressure), cerebral infarction (brain tissue death caused by blocked blood vessel in the brain), unspecified dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking and behavior), and under the advance directive section was listed DNR (Do Not Resuscitate). Record review of an admission MDS dated [DATE] indicated Resident #21 had adequate hearing, she had clear speech, she was able to make herself understood, she was able to understand others and she had moderately impaired cognition with a BIMS score of 10 out of 15. Record Review of Resident #21's Care Plan dated [DATE], indicated: focus of Resident request code status of: DNR., goal of Advance Directives are in effect, they will be carried out in accordance with resident's wishes. and interventions of Inform staff of code status. Record Review of Resident #21's physician order dated [DATE] indicated: communication method phone, order status Active, orders placed for DNR - Do Not Resuscitate. Record Review of Resident #21's OOH-DNR record indicated: Under the C section labeled, Declaration by qualified relative of the adult person adult child box was checked signed and dated [DATE]. Section labeled TWO WITNESSES indicated, Witness #1 signed the DNR, there was no date of when Witness #1 signed it, and Witness #2 signed, dated [DATE] two days after the qualified relative signed the DNR indicating the qualified relative signature was not witnessed. During an observation and interview on [DATE] at 9:30 a.m. Resident #21 was sitting in her wheelchair in her room. She said she was doing fine. She said she did not want anyone to do CPR on her, she just wanted to pass-on peacefully. Record Review of Resident 31's face sheet, dated [DATE], indicated a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses that included: emphysema (air sacs of the lungs are damaged and enlarged), adult failure to thrive (progressive physical and cognitive decline in older adults), and under the advance directive section was listed DNR (Do Not Resuscitate). Record review of a quarterly MDS dated [DATE] indicated Resident #31 had adequate hearing, he had clear speech, he was usually able to make himself understood, he was usually able to understand others and he had moderately impaired cognition with a BIMS score of 12 out of 15. Record Review of Resident #31's Care Plan dated [DATE], indicated: focus of Resident request code status of: DNR., and interventions of Make sure that code status is signed and in the active medical record. Record Review of Resident #31's physician order dated [DATE] indicated: communication method phone, order status Active, orders placed for DNR (Do Not Resuscitate). Record Review of Resident #31's OOH-DNR record indicated: in two separate print named areas on the DNR (Under the A section labeled, Person's legal full name and the printed name) his last two letters in his first name were altered by scribble and written over letters. The two last letters of Resident #31's first name were darker than the other letters in his name indicating written over to correct misspelling. During an observation and interview on [DATE] at 10:28 a.m. Resident #31 was sitting in his wheelchair in his room. He said he did not want anyone to do CPR on him, he wanted to die in peace. During an interview on [DATE] at 12:00 PM, the SW said if a DNR form was not (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed correctly with accurate dates and signatures, the DNR would be invalid. The SW said it was the social worker's responsibility to ensure DNR forms were completed accurately to include signatures and dates. The SW said she must have not been looking in detail like she should have. The SW said she would check all the DNRs for proper completeness of signatures and dates. The SW said a resident's wishes may not have been followed if their advance directive was not completed. During an interview on [DATE] at 2:10 PM the DON said Advance Directives were reviewed by the admitting nurse and social worker to ensure accuracy. The DON said Advance Directives should be completed thoroughly to include dates that the document was witnessed, signed, and no scribble or written over letters. The DON verified there were no additional advance directives for Resident #21 or #31. The DON verified the current Advance Directives for Residents #21 and #31 were not completed. The DON said Resident #21's DNR #1 Witness did not have a dated signature and the date #2 Witness signed was 2 days after the adult relative had signed the DNR indicating the signing was not witnessed. The DON said Resident #31's DNR had written over letters and it should have been corrected with a cross out line and initialed or rewritten in its entirety. The DON said it was important for Advance Directives to be completed thoroughly to ensure the documents were legally binding. The DON said if an advance directive was not completed, the resident's wishes may not be honored. The DON said she would ensure the advance directives for Resident #21 and #31 were updated as soon as possible. During an interview on [DATE] at 2:30 p.m. the Administrator said if a DNR form was not completed correctly with accurate dates and signatures, the DNR would be invalid. She said that in such a case, staff would be required to initiate CPR, which would go against the resident's expressed wishes. The Administrator said she believed it was the social worker's responsibility to ensure DNR forms were completed accurately and in accordance with requirements, The Administrator said hospice services obtained the DNR on Resident #21 and should have ensured it was complete but ultimately it was the facility's responsibility. The Administrator said the negative outcome would be the resident could have CPR performed on them against their wishes and she would check the other Residents with DNRs for completeness. Record review of the facility admission packet for potential residents, page #50 read: . an OOH DNR Order form must be Properly executed in accordance with the instructions on the opposite side to be considered a valid form by emergency medical services personnel. Record review of a Do Not Resuscitate Order back page instructions read, .the OOH-DNR order Must be signed and dated by two competent adult witnesses who have witnessed either the competent adult person making his or her signature in section A. The original or copy of a fully and properly completed OOH-DNR order or the presence of an out of hospital DNR device on a person is sufficient evidence of the existence of the original out of hospital DNR order and either one shall be honored by responding health care professionals.		

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 12/10/2025
NAME OF PROVIDER OR SUPPLIER Mill Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 W Hwy 418 Silsbee, TX 77656	
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Resident #2). The facility failed to develop Resident #2's comprehensive care plan that addressed 3 scabbed skin tears on left 2nd toe- 0.50 cm, 3rd toe- 1.20 cm x 1.00 cm, x 0.50 cm, left 4th toe- 1.30 cm x 0.40 cm. This failure could place residents at risk for not receiving necessary treatment and care. Findings included: Record review of Resident #2's face sheet, dated 12/08/2025 indicated she is a [AGE] year-old female that was re-admitted to the facility 11/09/2025. Diagnoses included- type 2 diabetes, periprosthetic fracture around internal prosthetic left knee joint (a fracture around a knee joint replacement), weakness, candidiasis of skin and nails (fungal growth on nails and skin), lack of coordination, edema (swelling on body). Record review of Resident #2's Quarterly MDS, dated [DATE] indicated she had a BIMS score of 15, indicating she was cognitively intact. In section N - medications- Resident #2 was taking insulin injections that control her blood sugar. Section M- skin conditions indicated clinical assessments were needed to determine her risk for pressure ulcers and risk for injury. Resident #2 was at risk for developing pressure ulcers and injuries. Resident #2 had no unhealed pressure ulcers or ulcer/ injuries at readmission, diabetic foot ulcers, other lesions on the foot skin tears, or moisture associated skin damage. (11/09/2025) Record review of Resident #2's care plan, dated 11/06/2025, indicated 3 scabbed skin tears on left 2nd toe- 0.50 cm 3rd toe- 1.20 cm x 1.00 cm, x 0.50 cm, left 4th toe- 1.30 cm x 0.40 cm had not been care planned nor were there interventions listed that addressed what kind of wound care treatment was needed. Resident #2's care plan stated The resident has Diabetes Mellitus and is currently receiving Insulin lispro, glargine. Interventions: Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. During an observation and interview on 12/08/2025 at 10:00 a.m., Resident #2 had 3 scabbed skin tears on left 2nd toe- 0.50 cm left 3rd toe- 1.20 cm x 1.00 cm, x 0.50 cm, left 4th toe- 1.30 cm x 0.40 cm. During an interview with Resident #2 she said she was not aware or had been told that she had any skin issues on her toes. She said no one was doing wound care on her feet. During an interview with LVN B on 12/09/2025 at 10:30 a.m., she said Resident #2 had not had a care plan addressing her 3 skin tears on her 2nd, 3rd, and 4th toe on the left foot. She said infection could potentially be a risk to Resident #2 if her 3 skin tears on her 2nd, 3rd, and 4th toe on the left foot was not care planned. During an interview with the Wound Care Nurse on 12/09/2025 at 10:49 a.m., she said she was responsible for updating wound care plans, and the DON initiates the wound care plans. She said Resident #2's 3 skin tears to her left foot had not been care planned because she had not noticed them during her daily skin assessments. She said Resident #2's 3 skin tears should have been care planned. She said she had been trained and in-serviced on the importance of updating residents' care plans. She said infection and diabetic ulcers could potentially be a risk to residents if not care planned. During an interview with the DON on 12/10/2025 at 12:00 p.m., she said she was responsible for initiating wound care plans and the Wound Care Nurse was responsible for updating the care plan. She said the Wound Care Nurse does a daily skilled skin assessment on Resident #2. She said Resident #2 had 3 skin abrasions to her left foot, not 3 skin tears. She said her expectation was for care plans to be accurate, effective, and meet the needs of residents. She said staff had been trained and in-serviced on the importance and need for care plans. The DON said Resident #2 should have had a care plan for her 3 left foot toes to ensure she received wound care treatment. She said the associated risk to Resident #2 could be infection and diabetic ulcers. During an interview with the Administrator on 12/10/2025 at 12:15 p.m., she said her expectations were for nursing staff, as a team, care plan residents' needs to ensure they receive (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment that's needed. She said Resident #2 should have had a care plan that addressed the needed care for her 3 toes on her left foot. She said staff had been trained and in-serviced on care plans. She said not having a care plan that addressed Resident #2's needs could potentially cause the resident not receiving needed care or services. Record review of facility policy titled Comprehensive Care Plans undated indicated: In part- Policy:It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Definitions: Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. Professional standards of quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Policy Explanation and Compliance Guidelines:1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma-informed care as indicated.2. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan.b. A registered nurse with responsibility for the resident.c. A nurse aide with responsibility for the resident.d. A member of the food and nutrition services staff.e. The resident and the resident's representative, to the extent practicable.f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:i. The RAI Coordinator.ii. Activities Director/Staff.iii. Social Services Director/Social Worker.iv. Licensed therapists.v. Family members, surrogate, or others desired by the resident.vi. Administration.vii. Discharge Coordinator.viii. Mental health professional.ix. Chaplain.3. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.4. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.5. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.6. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident was given the appropriate treatment and services to a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #2) reviewed for activities of daily living. The facility failed to clean, trim, and clip Resident #2's nails. Resident #2 nails were not clean, trimmed, nor cut. Resident #2's middle finger on her right finger was sharp, uneven, and jagged edged, four nails (pinky and thumb on right hand and thumb and index finger) were approximately 1 cm in length, and all her nails had thick dark brown and yellow substance underneath fingernails. This failure could place residents at risk of activities of daily living decline, frustration, and decreased socialization. Findings included: Record review of Resident #2's face sheet, dated 12/08/2025 indicated she is a [AGE] year-old female that was re-admitted to the facility 11/09/2025. Diagnoses included periprosthetic fracture around internal prosthetic left knee joint (a fracture around a knee joint replacement), weakness, candidiasis of skin and nails (fungal growth on nails and skin), lack of coordination, edema (swelling on the body), type 2 diabetes. Record review of Resident #2's MDS, dated [DATE] indicated she had a BIMS score of 15, indicating she was cognitively intact. In section GG- Functional Abilities- Resident #2 required extensive assistance with ADLs such as personal hygiene. Record review of Resident #2's care plan, dated 11/06/2025, indicated Resident #2 had a focus of The resident has an ADL self-care performance deficit related to weakness and an intervention of: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Resident #2 was care planned for diabetes with interventions: That nails should always be cut straight across, never cut corners. File rough edges with emery board. During an observation and interview with Resident #2 on 12/09/2025 at 9:05 a.m., Resident #2's nails were not clean, trimmed, nor cut. Resident #2's middle finger on her right finger was sharp, uneven, and jagged edged, four nails (pinky and thumb on right hand and thumb and index finger) were approximately 1 cm in length, and all her nails had thick dark brown and yellow substance underneath fingernails. During an interview with Resident #2, she said she liked her fingernails cleaned and cut. She said she had never had her nails that long before and had asked a nurse (she could not recall the nurse's name) to cut them. She said staff never came to cut her nails after she asked over a month ago. During an interview with the DON on 12/09/2025 at 9:45 a.m., she said staff should have cleaned, trimmed, and cut Resident #2's nails since she requested it. She said it's the CNAs, nurses, and her responsibility to ensure the residents have been taken care of collectively as a team. The DON said if residents' nails aren't cleaned, trimmed, or cut if can lead to unwanted breaks in skin, infection, and a decline in activities of daily living. During an interview with the Administrator on 12/09/2025 at 9:55 a.m., she said she expected staff to clean, trim, and cut Resident #2's nails as she requested. She said she expected staff to check Resident #2's nails regularly and as needed to see if activities of daily care (nail care) were needed. During an interview with the Regional Director of clinical services on 12/09/2025 at 10:00 a.m., she said Resident #2's nails should be cleaned, trimmed, and cut as stated in the care plan. She said she expected staff to inspect residents' nails and offer activities of daily living- nail care. Record review of the facility's policy Activities of Daily Living (ADLs) dated 2025, indicated: In part- Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks; and 5. Using speech, language or other functional communication systems. Policy Explanation and Compliance Guidelines: 1. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 2 of 6 residents (Resident #33, Resident #6) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #33 did not have a blue razor. (Resident #33 pulled out of her backpack and handed it to CNA A to shave her face with.2.The facility failed to ensure Resident #6 did not have an uncapped blue razor on top of his bedside dresser. These failures could place residents at an increased risk for injuries.Findings included: Record review of Resident #33's face sheet dated 12/08/2025 indicated she was a [AGE] year-old female that was admitted to the facility 09/22/2021 with diagnoses of hemiplegia (stroke) and hemiparesis (weakness on one side of the body) affecting right dominant side, candidiasis (fungi growth), and aphasia (inability to understand or produce speech.) Record review of Resident #33's Quarterly MDS assessment revision dated 11/6/2025 indicated she had a BIMs of 7 which indicated her cognition was severely impaired. In section B- hearing, speech, and vision indicated she was understood and understood others was understood. The MDS assessment indicated Resident #33 required substantial/maximal assistance with toileting, personal hygiene, showering/bathing, lower body dressing and partial/moderate assistance with upper body dressing.Record review of Resident #33's care plan 11/6/2025 dated did not address items she could not keep in her room.During an observation on 12/8/2025 at 9:43 a.m., Resident #33 asked CNA A to shave her face to remove chin and mustache hairs. CNA A asked Resident #33 if she had a razor in her dresser to use. Resident #33 said there should be one in there. CNA A opened Resident #33's bedside dresser and began looking for a razor. CNA A said to Resident #33 that she didn't find one in her dresser and would have to get one. Resident #33 told CNA A I have one here. Resident #33 unzipped her backpack and retrieved a clear packaged blue razor then handed it to CNA A. CNA A asked Resident #33 where she got the razor from, Resident #33 said I don't know. CNA A told Resident #33 that she didn't know she had a razor and that she should not have had one.During an interview with CNA A on 12/8/2025 at 10:15 a.m., CNA A said she had seen razors in Resident #33's bedside dresser in the past but could not recall when, nor how many times. She said Resident #33 should not have had the blue razor. She said she discarded it after using it in the sharps container. CNA A said the failure could have placed residents at risk for injury to all residents in the unit. During an interview with LVN C on 12/8/2025 at 11:20 a.m., LVN C said Resident #33 should not have a razor. She said she was not aware Resident #33 had a razor. She said the failure placed a risk for any of the residents harming themselves. LVN C said all staff were responsible for ensuring the items were not in the residents' rooms. During an interview with the DON on 12/8/2025 at 1:40 p.m., the DON said Resident #33 did not have razors care planned. She said the facility did not have a policy that addressed residents having razors or what a resident is not allowed and allowed to bring from home. She said a resident with a lower BIMS score should not have had a razor in their possession. She said all staff were responsible for ensuring razors were secured by staff. She said the failure could have placed residents at a risk for using the items inappropriately.During an interview with the Regional Director of Clinical Services on 12/8/2025 at 1:50 p.m., she said I have the same answer as the DON regarding the razor.During an interview with the Administrator on 12/8/2025 at 2:00 p.m., the Administrator said Resident #33 should not have had the razor. She said staff are the only ones with access to razors. The Administrator said all staff were responsible for ensuring razors are kept secure. She said the failure could place residents at risk for injuries or using them inappropriately.Resident #6 Record review of Resident #6's face sheet dated 12/10/2025 indicated that he was a [AGE] year-old male that was re-admitted to the facility 9/11/2025 with diagnoses of hypertensive heart disease without heart failure (high blood pressure), (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	paranoid schizophrenia (delusions, hallucinations), intermittent explosive disorder (sudden, impulsive, and aggressive outbursts of rage), Alzheimer's disease (memory loss, confusion, personality changes), unspecified dementia, moderate with mood disturbances (memory and thinking problems that are significant enough to impact daily life and include emotional issues like depression, apathy, or anxiety.)Record review of Resident #6's Quarterly MDS dated [DATE] indicated he had a BIMS score of 7 indicated which indicated he was cognition was severely impaired. In section B- (hearing, speech, and vision) it indicated he can make himself understood by others and he understood others. The MDS assessment indicated Resident #33 required partial/moderate to supervision assistance with toileting, personal hygiene, showering/bathing, lower body dressing and upper body dressing.Record review of Resident #6's revision care plan dated 12/02/2025 did not address items he could not keep in his room.During an observation on 12/8/2025 at 11:02 a.m., an uncapped blue razor was on top of Resident #6's bedside dresser. During an interview on 12/8/2025 at 11:03 a.m., LVN D she said she had not known how long the razor had been on the dresser for. She said Resident #6 relies on staff to shave him. She said she did not know when the last time Resident #6 was shaved. LVN D said Resident #6 should not have access to razors due to the potential risk of injury to himself, his roommate, or staff. She said it was her responsibility to ensure residents do not have items that could cause potential injury. She said she had been trained and in-serviced on accidents and hazards. During an interview on 12/8/2025 at 1:43 p.m., with the DON, she said Resident #6 did not have razors care planned. She said the facility did not have a policy that addressed residents having razors or what a resident is not allowed and allowed to bring from home. She said a resident with a lower BIMS score should not have had a razor in their possession. She said all staff were responsible for ensuring razors were secured by staff. She said the failure could have placed residents at a risk for using the items inappropriately.During an interview with the regional director of clinical services on 12/8/2025 at 1:55 p.m., she said I have the same answer as the DON regarding the razor. During an interview with the Administrator on 12/8/2025 at 2:10 p.m., the Administrator said Resident #6 should not have had the razor. She said staff are the only ones with access to razors. The Administrator said all staff were responsible for ensuring razors are kept secure. She said she did not know when the last time Resident #6 was shaved. She said the failure could place residents at risk for injuries or using them inappropriately. Record review for facility's policy on razors was attempted to be obtained. The DON, the Administrator, and the Regional Director of Clinical Services said the facility did not have a policy in place that addressed residents having razors nor the allowed items residents can have on person.		