STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK CENTER FOR NURSING AND REHABILITATION	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced compliant investigation survey was conducted on 9/28/23. Event ID # DWIX11. The following intake were investigated NC00207782. 1 of 1 complaint allegations resulted in a deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		10/19/23

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

Electronically Signed | 10/18/2023

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F 656	Continued From page 1 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the individualized comprehensive care plan to include additional interventions implemented for 1 of 3 residents reviewed for smoking (Resident #1). The findings included: Resident #1 was admitted to the facility on 4/6/23 with diagnoses of spinal stenosis of cervical region and other specified behavioral and emotional disorders. The admission Minimum Data Set (MDS) dated 4/7/23 revealed Resident #1 was cognitively intact. Review of the smoking assessment dated 4/9/23 revealed Resident #1 was assessed to be a supervised smoker.	F 656	Regarding the alleged deficient practice of failure to revise the individualized comprehensive care plan to include additional interventions for smoking resident #1 - Resident #1 was re-educated after each incident of suspected smoking or when she had admitted smoking on dates 6/12/23 and 8/3/23 by the social worker and nursing, however, the care plan did not reflect the interventions that took place. All residents have the potential to be affected. On 9/28/23, the Staff Development Coordinator (SDC) in-serviced all nurses to initiate an incident report for any smoking policy violations. By 10/19/2023, the Administrator will re-educate MDS (Minimal Data Set)	

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F 656	Continued From page 2 Review of the care plan dated 6/7/23 for Resident #1 revealed she was a supervised smoker and would not smoke without supervision. Interventions included to instruct the resident about the smoking risks, and hazards and about smoking cessation aids that are available, instruct resident about the facility policy on smoking, locations, times, safety concerns, monitor oral hygiene, notify charge nurse immediately if resident is suspected of violating the smoking policy, observe clothing and skin for signs of cigarette burns, and resident is required to be supervised while smoking. On 6/12/23 Resident #1 was found smoking in room, staff re-educated Resident #1 on safe smoking. On 8/3/23, Resident #1's room smelled of smoke and staff re-educated the resident on the smoking policy. An interview was conducted with the MDS coordinator on 9/28/23 at 2:27pm. The care plan was reviewed, and she confirmed that she was aware of the smoking incidents on 6/12/23 and 8/3/23 and that staff had discussed safety concerns and re-educated the resident on the smoking policy but there were not any additional interventions added to the care plan. regarding the smoking incidents that occurred on 6/12/23 and 8/3/23. An interview was conducted with the Administrator on 9/28/23 at 5:48 PM. She confirmed that additional smoking interventions should have been updated on Resident #1's smoking care plan after each smoking related incident that occurred on 6/12/23 and 8/3/23.	F 656	Coordinators to update the resident care plan with additional interventions after a resident is found to have violated the facility's smoking policy. MDS Coordinators will conduct 8 care plan audits a week times 4 weeks and then 5 care plan audits a week times 4 weeks to ensure care plans are accurately updated. Director of Nursing (DON) will review the plan during Quality Assurance committee meetings times 3 months and continue audits at the discretion of the committee. Completion date: 10/19/23	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/20/23

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F 689	Continued From page 3 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide affective supervision to a resident assessed as needing supervision with smoking when the resident was found to be smoking in her private room for 1 of 3 residents reviewed for smoking (Resident #1). The findings included: Resident #1 was admitted to the facility on 4/6/23 with diagnoses of spinal stenosis of cervical region and other specified behavioral and emotional disorders. The admission Minimum Data Set (MDS) dated 4/7/23 revealed Resident #1 was cognitively intact, was not a smoker and did not use oxygen. Review of the smoking assessment dated 4/9/23 revealed Resident #1 was assessed to be a supervised smoker. Review of nursing progress note dated 6/1/23 revealed that Nurse #1 found Resident #1 smoking in room with the windows open. An interview was conducted on 9/28/23 at	F 689	Regarding the alleged deficient practice of failure to provide adequate supervision to prevent accidents as evidenced by: - Failing to provide effective supervision to Resident #1 assessed as needing supervision with smoking when the resident was found to be smoking in her private room. Resident #1 was re-educated by the nurse on 6/1/23 and by the Social Worker on 6/12/23 of the smoking policy and all smoking materials were given to staff when asked of the resident. Resident #1 was issued a 30-day notice because the safety of individuals in the facility was being endangered due to the clinical/behavioral status of Resident #1 on 8/15/23 and was discharged on 9/15/23. All residents have the potential to be affected. On 9/28/23, the Staff Development Coordinator (SDC) in-serviced all nurses to initiate an incident report for any smoking policy violations. By 10/18/23, SDC had all current smoking	

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F 689	Continued From page 4 4:38pm with Nurse #1 and revealed on 6/1/23 that she had observed Resident #1 smoking in her private room. Resident #1 was reeducated on the smoking policy, smoking materials were removed from the room, and the director of nursing was notified. There was no oxygen found near Resident #1's room at that time. Review of the care plan dated 6/7/23 for Resident #1 revealed she was a supervised smoker and would not smoke without supervision. Interventions included to instruct the resident about the smoking risks, and hazards and about smoking cessation aids that are available, instruct resident about the facility policy on smoking, locations, times, safety concerns, monitor oral hygiene, notify charge nurse immediately if resident is suspected of violating the smoking policy, observe clothing and skin for signs of cigarette burns, and resident is required to be supervised while smoking. A review of social service progress note dated 6/12/23 revealed Resident #1 was smoking in her room again. An interview was conducted with the social worker on 9/28/23 at 2:21 PM and she revealed that on 6/12/23 she observed Resident #1's room smelled of smoke and Resident #1 told her that she had been smoking in the room. There was no oxygen found to be near Resident #1's room at that time. Resident #1 was reeducated on the smoking policy and her cigarettes and lighter were taken and given to activities director to store and provide to Resident #1 as requested at the next supervised smoking time. A review of nursing progress note dated 8/3/23	F 689	residents re-sign the Resident Smoking Policy that was signed upon admission and gave the resident a copy, which included potential interventions that would take place if there was a smoking violation. A full 100% audit of all resident smoking assessments was updated and completed by 10/18/23 by SDC and Unit Managers. Unit Managers will call RPs of identified smoking residents to inform them that all smoking materials must be given to the nurse or Activities department for safe-keeping to use during designated smoking times by 10/20/23. Also, by 10/20/23, SDC will educate all nurses to have the resident sign off on the facility smoking policy upon recognizing a resident is a smoker and educate all staff on what to do if a resident is seen smoking outside of designated smoking times, has smoking materials, or any suspicion of smoking violations. IDT will review new admits to ensure the smoking policy is signed by the resident if they are a smoker. SDC or Unit Manager will conduct audits of all new admissions to ensure smoking residents have signed off on the Resident Smoking Policy upon completing a smoking assessment with a current smoker, and that any RP has been called and notified of needing to give smoking materials to nursing or activities personnel 3 times per week times 6 weeks then weekly for 6 weeks. Director of Nursing (DON) will review the plan during Quality Assurance committee	

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F 689	Continued From page 5 revealed that Nurse #2 observed a rolled-up blanket under the door while entering and the room. The room smelled of smoke, but Resident #1 denied smoking. An interview was conducted on 9/28/23 at 12:59 pm with Nurse #2 and she revealed on 8/3/23 that she observed a rolled-up towel on the floor at the base of the door and that the room smelled of smoke. There was no oxygen found near Resident #1's room at that time. Resident #1 was reminded of the smoking policy again. Resident #1 was issued a notice of transfer/discharge on 8/15/23 (safety of individuals in this facility was endangered due to the clinical or behavioral status of this resident) and was discharged to the community on 9/15/23. An interview on 9/28/23 at 5:48 PM with the Administrator revealed that supervised smokers were required to follow the stated smoking policy and smoking materials were to be stored by activity staff in a locked box. She further revealed that smoking was not allowed indoors and only allowed outside in the designated smoking area. The Administrator stated Resident #1's known smoking materials were stored by staff however she had suspected that Resident #1 had acquired more smoking materials when she was out on leave of absence.	F 689	meetings times 3 months and continue audits at the discretion of the committee. Completion Date: 10/20/23	