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 04/14/2025

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/31/25 through 4/4/25. Additional information was obtained on 4/11/25 and 4/14/25. Therefore, the exit date was changed to 4/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DCT811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/31/25 through 4/4/25. Additional information was obtained on 4/11/25 and 4/14/25. Therefore, the exit date was changed to 4/14/25. Event ID #DCT811. The following intakes were investigated NC00222436, NC00221906, NC00220950 and NC00220873. 4 of the 14 complaint allegations resulted in deficiency. The 2567 was amended on 5/16/25 to reflect changes as result of IDR.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		5/12/25

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

Electronically Signed | 05/05/2025

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 04/14/2025

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 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to respect a resident's right to dignity when Resident #212 requested incontinence care and it was not provided until after all the meals trays were passed on the hall for 1 of 1 resident reviewed for dignity (Resident #212). The findings included:	F 550	Resident #212 received incontinence care on the morning of 4/1/25 after the concern was identified. Incontinent residents have the potential to be affected. An audit of incontinent residents was initiated on 4/29/25 by the Director of Nursing. Interviews with incontinent alert and oriented residents were conducted and skin assessments	

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 04/14/2025

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 550	Continued From page 2 Resident #212 was admitted to the facility on 3/10/25 with diagnoses including bowel and bladder incontinence due to impaired mobility, and osteomyelitis. Resident #212's self-care deficit care plan dated 3/13/25 indicated staff were to aid with bowel and bladder incontinence related to immobility. The admission Minimum Data Set (MDS) dated 3/17/25 specified that Resident #212 was cognitively intact and dependent on toileting, dressing, bathing, transfers, and mobility care. The MDS also determined that the Resident required a mechanical lift for transfers. There were no indications of behaviors exhibited. The MDS indicated Resident #212 was frequently incontinent of bowel and bladder. An observation was conducted in conjunction with an interview with Resident 212 on 4/1/25 at 8:30 AM. When approaching Resident 212's room a strong odor of feces was noted. Upon entrance to Resident 212's room it was discovered the odor was coming from Resident #212's room. Resident #212 was interviewed, he stated he needed to be changed and had been waiting since before "light" (outside). The Resident stated they brought him his breakfast tray, but he had them remove it because he "could not eat in that mess." Nurse Aide (NA) #1 was notified of Resident #212's request for incontinence care. An observation of incontinence care and an interview occurred with NA #1 and NA #2 on 4/01/25 at 8:40 AM. NA #1 stated they found him like that every time they work, and the 11:00 PM to 7:00 AM shift "always leaves him (Resident	F 550	were completed for non-alert and oriented residents for potential skin breakdown. Any identified issues or concerns were reviewed and addressed by Nursing Administration. On 4/30/25, the Staff Development Coordinator initiated education to nursing staff on honoring residents rights and dignity with emphasis on providing incontinence care as requested and not turn off a call light until the requested service is rendered. Newly hired nursing staff will receive the education during orientation from the Staff Development Coordinator. Staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Director of Nursing or designee will audit five incontinent residents during mealtimes for 4 weeks, then two residents for 2 weeks, then one resident a week for 2 weeks to ensure incontinent needs are met before meal trays are delivered. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed	

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 04/14/2025

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 550	Continued From page 3	F 550		

#212) for us to clean up." When the NAs were asked why they didn't round on the resident earlier in their shift, they stated they were not supposed to do patient care while the trays were out. NA #1 further indicated the residents should be cleaned up by the 11:00 PM to 7:00 AM shift and ready for breakfast. NA #1 also stated the trays came out right after they arrived at 7:00 AM, and Resident #212 always needed cleaning up first thing in the morning, but they could not do patient care while the trays were being passed.

On 4/01/25 at 9:06 AM, a follow-up interview with Resident #212 revealed that he turned his call light on and had asked the third shift (11:00 PM to 7:00 AM) aide, NA #5, to clean him up. He said NA #5 answered his light, turned it off, said she would return to provide incontinence care, left the room, and did not return. Resident #212 stated this treatment had been going on since his admission. He further said it was still dark outside when he rang for NA #5 but could not recall the exact time. Resident #212 noted the next shift (7:00 AM to 3:00 PM) NA came into his room around 7:00 AM with his breakfast tray, but did not provide care; it was light outside by this time. The resident recalled that NA #1 came in with his breakfast tray and told him she would clean him up after all the trays were passed. Resident #212 stated that he felt disgusted about "sitting in this mess" and being expected to eat breakfast like that. He asked NA #1 to put the tray back on the cart until he was cleaned up. The tray was removed by NA #1 and placed back on the cart until he was cleaned up. The resident further stated he was left in his soiled brief until after the breakfast trays were passed. He said, "I can do bad at home by myself."

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 04/14/2025

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 550	Continued From page 4 Attempts were made to interview NA #5 by phone, but she did not return calls. An interview on 4/02/25 at 10:00 AM with Nurse # 4 (Unit Manager) revealed that the 11:00 PM to 7:00 AM shift should have the residents clean and dry for breakfast because the trays came out around 7:00 AM. An interview with the Director of Nursing (DON) on 4/04/25 at 9:45 AM revealed the staff should ensure the residents are clean and dry before breakfast on the first shift. She stated it was unacceptable for the residents to lie in soiled briefs while being expected to eat. She further noted that if a resident needed incontinence care, the staff should leave their tray on the cart and give incontinence care so they will be clean for the meal. The DON indicated the staff should treat the residents with dignity and not allow them to feel sad or like the staff did not care about them.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to assess and document the ability of a resident to self-administer medications for 1 of 2 residents (Resident #38) reviewed for medication self-administration.	F 554	Resident #38's nasal spray was removed from the bedside on 4/1/25 after the issue was identified. A medication reconciliation was conducted, and the physician was notified. Current residents have the potential to be affected. An audit was initiated on 4/29/25	5/12/25

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 04/14/2025

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 554	Continued From page 5 Findings included: Resident #38 was admitted to the facility on 11/9/23. The quarterly Minimum Data Set assessment dated 2/12/25 revealed Resident #38 was cognitively intact. On 4/1/25 at 9:53 am, an observation was made of fluticasone propionate nasal spray (a steroid nasal spray to treat allergic rhinitis) sitting on Resident #38's bedside table. During an interview with Resident #38 on 4/1/25 at 10:35 am he stated that he used the nasal spray a couple times a day when he needed to for his stuffy nose. Resident #38 reported he couldn't remember who gave the nasal spray to him but he had been using it for a month or two. A care plan last revised on 2/18/25 revealed Resident #38 did not have a care plan to address self-administration of medications. A review of physician orders for Resident #38 there was no order for fluticasone propionate nasal spray. During an interview with Nurse #2 on 4/1/25 at 10:40 am, she stated she was assigned to Resident #38 often but had never noticed the nasal spray on his bedside table before. She reported she was unsure if he had been assessed to self-administer any medications. During an interview on 4/1/25 at 11:00 am with the Director of Nursing (DON), she stated Resident #38 had never been assessed for	F 554	by the Director of Nursing, Staff Development Coordinator, and Unit Manager to identify any other residents who had medications at bedside. Any residents that were found with medications at bedside without corresponding self-administration assessments or an order were removed until an assessment was completed. If the assessment shows the resident was deemed appropriate, physician orders were obtained, and care plans were updated accordingly. On 4/30/25, the Staff Development Coordinator initiated education to nurses and medication aides about residents with medications at bedside needing to be assessed to ensure it is clinically appropriate and the need for a provider's order to do so. Newly hired nurses and medication aides will receive the education during orientation from the Staff Development Coordinator. Staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Director of Nursing or designee will audit five resident rooms weekly for 4 weeks, then three resident rooms weekly for 2 weeks, then one resident room per week for 2 weeks to ensure medications are not stored at bedside without appropriate orders and assessments. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance	

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 04/14/2025

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 554	Continued From page 6 self-administration of any medication. The DON reported if a resident wanted to have medications at their bedside there should be an order and an assessment for self-administration of medications.	F 554	Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to ensure the accessibility of a wheelchair for 1 of 1 resident (Resident #1) reviewed for reasonable accommodations of needs. Findings included: Resident #1 was admitted to the facility on 1/23/19 and readmitted on 2/18/25 with diagnoses which included: osteomyelitis, cerebral infarction, and diabetes mellitus. The quarterly Minimum Data Set assessment dated 2/8/25 indicated Resident #1 was cognitively intact; and was totally dependent on staff and a mechanical lift for transfers. During an observation and interview on 3/31/25 at 1:20 p.m., Resident #1 revealed he had not attended the out of room group activities because he had not seen his wheelchair since his return	F 558	Resident #1's labeled bariatric wheelchair was located on 4/4/25 in a therapy storage room and returned to the resident's room. Staff assisted transferring him to the wheelchair after his meal per his request. Residents who utilize or require ambulatory equipment have the potential to be affected. An audit was initiated by the Director of Rehabilitation on 4/28/25 to ensure each resident had the appropriate assigned and labeled ambulatory medical equipment. On 4/30/25, the Staff Development Coordinator initiated education to the nursing, therapy, and environmental services departments on ensuring resident-assigned mobility equipment is maintained in or near the resident's room and remains readily accessible. Staff were reminded that cognitively intact residents may decline assistance but can still be	5/12/25

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 04/14/2025

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 558	Continued From page 7 from the hospital (2/18/25). The resident stated that prior to his hospitalization he would use the wheelchair to propel himself to the group activities. An observation of the resident's room and bathroom revealed there was no wheelchair in Resident #1's room or bathroom. On 4/3/25 at 1:50 p.m., Resident#1 was observed awake, lying in his bed. There was no wheelchair in the resident's room or bathroom. An interview was conducted on 4/3/25 at 3:00 p.m. with Nursing Assistant (NA) #8 who stated she had been working at the facility approximately 2 to 3 months during second shift (3:00 PM to 11:00 PM). NA #8 stated Resident #1 had never requested to get out of bed but acknowledged she never asked the resident if he wanted to get out of his bed to his wheelchair. The NA #8 indicated she was not aware there was no wheelchair in the resident's room or bathroom. During an interview on 4/3/25 at 3:05 p.m., NA #9 stated the resident currently required the use of the mechanical lift and two nursing assistants for transfers in and out of bed. Resident #1 did not like the use of the mechanical lift and would refuse to get out of bed. She recalled the resident's wheelchair had not been in his room for approximately three weeks, when the resident's room was deep cleaned. On 4/3/25 at 3:46 p.m., NA #7 stated that she worked every other weekend and whenever needed during second shift. NA#7 stated that she last worked with Resident #1 approximately two months ago. She revealed the resident used to get out of bed and was able to propel himself in his wheelchair. NA #7 indicated Resident #1	F 558	offered routine opportunities for out-of-bed activity and be provided with the equipment necessary to participate. Environmental services staff were directed to ensure resident equipment is returned to the appropriate room after cleaning. Newly hired nursing, therapy, or environmental services will receive the education during orientation from the Staff Development Coordinator. Staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Director of Rehabilitation or designee will audit five residents weekly for 4 weeks, then three residents weekly for 2 weeks, then one resident a week for 2 weeks to ensure equipment is present, accessible, and accurate to the resident's ambulatory status. The Director of Rehabilitation or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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 04/14/2025

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 558	Continued From page 8 never requested to get out of bed since his return from the hospital. NA #7 acknowledged she never asked the resident if he wanted to get out of the bed and was not aware there was not a wheelchair in the resident's room or bathroom. During an interview on 4/4/25 at 10:07 a.m., the Interim Rehabilitation Director stated that on 4/1/25 she attempted to work with Resident #1 for out of bed tolerance for sitting on the side of his bed for activities of daily living and unsupported sitting balance on the side of his bed but the resident refused. The Interim Rehabilitation Director did not recall observing the resident's wheelchair in his room. On 4/4/25 at 10:12 a.m., during a follow-up interview, the Interim Rehabilitation Director stated that after the interview with this Surveyor, she was able to locate Resident#1's bariatric wheelchair on the second floor, in the empty therapy room which was used by the facility as a storage room. She revealed the bariatric wheelchair was labeled with the resident's name. The Interim Rehabilitation Director further stated she went to Resident#1's room and asked if he wanted to get out of his bed to his wheelchair. The resident replied yes, after his meal. She stated she informed the nursing staff.	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as	F 577		5/12/25

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 04/14/2025

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 577	Continued From page 9 client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, a Resident Council Meeting, and staff interviews, the facility failed to post the survey results in a location accessible to the residents. The findings included: While entering the facility on 04/02/25 at 8:00 AM, an observation revealed the survey results binder was in the lobby on a table. The facility's lobby area was enclosed and secured by a door requiring a code to be entered for staff and residents to access. The Resident Council meeting was held on 04/02/25 at 1:30 PM. During the meeting, Resident #9, Resident #28, Resident #35, and Resident #12 stated they were unaware that	F 577	After the resident council meeting on 4/2/25, The Activities Director informed Resident #9, Resident #28, Resident #35, and Resident #12 where the facilitys survey results binder is located. Current residents have the potential to be affected. On 4/2/25, the new facility survey binder location is hung in the hallway before the locked lobby door, where it is easily accessible and visible to residents and visitors. On 4/28/25 during the monthly Resident Council meeting, the Activities Director informed the residents on the new placement of the survey binder and educated them that the facility's survey results are always available to residents, their families, representatives, and visitors. Alert and	

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 04/14/2025

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 577	Continued From page 10 survey results were posted in the facility or where the results were located. The Resident Council President, Resident #18, attended the meeting and stated she was aware that survey results could be reviewed and that they were in the lobby. They all stated they were not able to access the lobby to review the survey binder. An interview with the Administrator on 04/02/25 at 2:39 PM indicated that the survey results binder was available to the residents in the lobby; they just needed to let someone know they would like to look at the survey results binder. The interview further revealed the door leading to the lobby was always locked and required a staff member to enter a code to unlock it.	F 577	oriented residents who were not present at the meeting were individually informed by the Activities Director on 4/29/25 regarding the new location of the survey results binder. On 4/30/25, the Staff Development Coordinator initiated education to staff regarding the survey binder placement within the facility. The education included that the survey results must be in a place where it is readily accessible to residents, family members, and legal representatives of residents. Newly hired staff will receive the education during orientation from the Staff Development Coordinator. Staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Administrator or designee will audit five alert and oriented residents per week for 4 weeks then three alert and oriented residents for 4 weeks to ensure that the residents are aware of where they can find the survey results and that they are aware that they have the right to view the results. The Activities Director or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		5/12/25

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 04/14/2025

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 578	Continued From page 11	F 578		

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide

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 04/14/2025

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 578	Continued From page 12 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide information to residents regarding the residents' right to accept or refuse medical/surgical treatment when formulating an advanced directive for 4 of 6 sampled residents reviewed for advanced directives (Residents #15, #25, #29, #39). Findings included: 1. Resident #15 was admitted to the facility on 12/22/23 and re-admitted on 1/13/25. The most recent Minimum Data Set assessment dated 1/20/25 indicated Resident #15 was cognitively intact. Review of the physician's order dated 2/4/25 documented Resident #15's Advance Directive status as Full Code. There was no documentation in Resident #15's medical record indicating the resident was provided information about his right to accept or decline medical or surgical treatment prior to making a Advance Directive decision. During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #15 had the right to accept or decline medical or surgical treatment. 2. Resident #25 was admitted to the facility on	F 578	On 4/28/25, the Social Worker met with Resident #15, who is cognitively intact, to review his right to accept or refuse medical and surgical treatment related to their advance directive choices. For Residents #29, #25 and #39, whose responsible parties make decisions, the Social Worker initiated contact to the responsible parties to review this information. Documentation of these discussions were completed and entered into residents' records. On 4/30/25 the Administrator initiated an audit of current residents to ensure documentation was present regarding resident and/or responsible party education on the right to accept or refuse medical or surgical treatment when formulating an Advance Directive. Any missing documentation will be addressed by the Social Worker, and education is to be provided as needed with corresponding entries made in the medical records. On 4/30/25, the Social Worker was educated by the Administrator regarding the expectation for documentation review and education of advanced directives at admission, quarterly care plan meetings, and whenever changes to advance directives are requested. The Administrator or designee will audit 100% of new admissions weekly for eight weeks to ensure that documentation of education about the right to accept or	

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 04/14/2025

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 578	Continued From page 13 2/22/24. The most recent Minimum Data Set assessment dated 2/10/25 indicated Resident #25 was severely cognitively impaired. Review of the physician's order dated 2/27/24 documented Resident #25's Advance Directive status as Full Code. There was no documentation in Resident #25's medical record indicating the resident or the resident's responsible party were provided information about the right to accept or decline medical or surgical treatment prior to making an Advance Directive decision. During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #25 had the right to accept or decline medical or surgical treatment. 3. Resident #29 was admitted to the facility on 1/23/25. The most recent minimum data set assessment dated 2/10/25 indicated Resident #29 was Review of the physician's order dated 1/23/25 documented Resident #29's Advance Directive status as Full Code. There was no documentation in Resident #29's medical record indicating the resident and the resident's responsible party were provided information about the right to accept or decline medical or surgical treatment prior to making an Advance Directive decision.	F 578	refuse treatment is completed. The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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 04/14/2025

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 578	Continued From page 14 During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #29 had the right to accept or decline medical or surgical treatment. 4. Resident #39 was admitted to the facility on 11/5/24. The most recent Minimum Data Set assessment dated 2/8/25 indicated Resident #39 was severely cognitively impaired. Review of the physician's order dated 12/24/24 documented Resident #39's Advance Directive status as Do Not Resuscitate. There was no documentation in Resident #39's medical record indicating the resident and the resident's responsible party were provided information about the right to accept or decline medical or surgical treatment prior to making an Advance Directive decision. During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #39 had the right to accept or decline medical or surgical treatment.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		5/12/25

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 04/14/2025

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 583	Continued From page 15 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the private health information for 3 of 3 sampled residents by posting confidential medical information in an area accessible to the public (Resident #11, Resident #22, and Resident #158). Findings included:	F 583	The posting of dialysis days and chair times for Resident #11, Resident #22, and Resident #158 was removed from behind the nursing station on 4/1/25 by the Director of Nursing. Residents with preplanned appointments have the potential to be affected. An audit of visible working stations where resident information may be posted was completed	

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 04/14/2025

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 583	Continued From page 16 During observations on the 100 and 200 halls on 4/1/25 at 9:51 a.m. and 9:52 a.m., one 8.5 inch x 11-inch white sheet of paper with the updated date of 3/12/25 was posted on the wall with tape located behind and next to 2 of 2 nurses' stations. The signs were documented with Resident #11, Resident #22, and Resident #158's names and medical information concerning the residents' dialysis treatments. The documentation on the signs was in large print, typed and had additional handwritten notes about each dialysis resident. The signs included the residents' names, days of the week each resident was scheduled for dialysis treatment, departure times from the facility, and dialysis procedure times. The posted signs on the walls were visible and readable to residents and visitors from the front of each of the nurses' station countertops. During an interview on 4/1/25 at 10:02 a.m., the Director of Nursing acknowledged and stated residents' medical information was displayed on the signs posted on the wall next to the nurses' stations on the 100 and 200 halls in full view of residents and visitors to the facility. She indicated the signs should not have been posted in areas for anyone other than nursing staff to view due to Health Information Portability and Accountability Act (HIPAA) violations.	F 583	on 4/28/25 by the Director of Nursing to identify any other instances of publicly displayed confidential medical information. On 4/30/25, the Staff Development Coordinator initiated education to staff regarding the proper handling and protection of resident Protected Health Information (PHI), emphasizing that resident-specific medical details should not be posted in publicly accessible areas. Newly hired staff will receive the education during orientation from the Staff Development Coordinator. Staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Administrator or designee will audit visible working stations four times a week for 4 weeks, then twice a week for 2 weeks, then once a week for 2 weeks to ensure Protective Health Information is not visibly posted or displayed in areas that are visible and readable to residents and visitors. The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		5/12/25

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 04/14/2025

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 584	Continued From page 17	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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 04/14/2025

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 584	Continued From page 18 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to ensure an electrical outlet was securely covered in Room #204 and failed to ensure resident's clothing was clean and stored neatly in sufficient storage spaces for two residents on the 200 hall. The deficient practice occurred on 1 of 2 halls observed for a clean and homelike environment (200 hall). Findings included: 1. An observation in Room #204 and interview of Resident #1 was conducted on 3/31/25 at 1:23 p.m. An electrical outlet cover located behind and to the left side of the head of Resident #1's bed was observed partially separated from the wall. There were two electrical cords inserted in the electrical outlet (attached to the bed and the air mattress on the bed) and both attached devices were functioning. The resident revealed he had not been out of his room since his return from the hospital (2/18/25). He indicated he was not aware of the condition of the electrical outlet. During a follow-up observation in Room #204 on 4/03/25 at 1:50 p.m., the electrical outlet cover located behind and to the left side of the head of Resident #1's bed continued to be partially separated from the wall. On 4/03/25 at 1:50 p.m. during an observation of the electrical outlet cover in Room #204 and an interview, the Environmental Services Director stated it appeared as if the electrical outlet cover was missing screws and should have been reported by the nursing staff and/or housekeeping	F 584	The identified outlet cover in room #204 was changed on 4/3/25 by the Maintenance Director. Rooms #217 and #216 were cleaned by the Environmental Services Manager on 4/4/25 and resident laundry was picked up off the floor and laundered. All residents have the potential to be affected. On 4/28/25, an audit was initiated by the Maintenance Director to identify any unsecured outlets. On 4/29/25, the Environmental Services Manager initiated an audit to identify any resident rooms that had resident clothing items on the floor or furniture and returned them to the appropriate wardrobe. On 4/28/25, the Director of Plant Operations educated the Maintenance Director regarding the importance of ensuring outlets are functioning correctly and are covered appropriately. On 4/30/25, the Staff Development Coordinator initiated education to staff to put maintenance requests into the electronic system, TELS, and the importance of keeping resident's laundry off the floor, and the importance of removing dirty laundry from resident rooms and bringing them to the dirty laundry area. Newly hired staff will receive the education during orientation from the Staff Development Coordinator. Staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Environmental Services Director or	

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 04/14/2025

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 584	Continued From page 19 staff when observed while cleaning the room An interview was conducted on 4/03/25 at 2:30 p.m. with the facility's Maintenance Director. He revealed none of the facility staff reported the outlet's condition in room #204 to the maintenance department. He explained that the facility's protocol for reporting maintenance repair needs was for them to be communicated to him via the Tels Program (an application on the facility's computers as well as the nursing assistants' automatic tasks and service access machine). The Maintenance Director indicated all facility staff were trained to input maintenance work order requests into the program in the computer. During an interview on 4/03/25 at 3:05 p.m., Nursing Assistant (NA) #9 revealed she was aware the outlet next to Resident #1's bed was partially pulled out from the socket and reported this to the staff nurse (no longer worked at the facility) in February 2025. 2.a. During an observation of Room #217 on 4/01/25 at 10:51 a.m., there was an overflowing large, clear plastic bag of clothes on the floor, beneath the vanity which was visible from the room's open doorway. Resident #29 revealed there were dirty clothes in the plastic bag and she would prefer the dirty clothes to be placed in some sort of container/laundry bag. On 4/03/25 at 1:51 p.m., a follow-up observation of Room #217 was conducted with the Environmental Services Director. The large clear, plastic bag of clothing remained on the floor beneath the vanity. The Environmental Services Director revealed residents' clothes were washed	F 584	designee will audit five resident rooms per week for 4 weeks, then four resident rooms for 2 weeks, and two resident rooms for 2 weeks to ensure resident laundry is not on the floor and piled on top of furniture. The Maintenance Director will inspect ten resident rooms or common areas for 4 weeks, then six for 2 weeks, then three for 2 weeks to ensure outlets are in good condition. The EVS and Maintenance Directors or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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 04/14/2025

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 584	Continued From page 20 and dried in the facility's laundry room twice each week (Tuesdays and Saturdays) and whenever needed. He further stated that if the nursing assistants brought residents' dirty clothes to the laundry room, there would not be dirty clothes piled in overflowing bags and stored on the floor beneath the vanity. During a third observation on 4/04/25 at 12:43 p.m. Room #217 a large, clear, plastic bag of clothing continued on the floor beneath the vanity. b. On 4/3/25 at 1:55 p.m., an observation of Room #216 from the opened doorway revealed multiple large, clear, plastic bags of clothing on the floor beneath the vanity and piles of clothing scattered on top of the vanity. Resident #15 resided in room #216 was in the hospital at the time of the observation. discharged to the hospital prior to the observation. On 4/4/25 at 1:55 p.m., during a follow-up observation of Room #216 clear, a large plastic bag of clothing continued on the floor beneath the vanity and piles of clothing continued to be on top of the vanity. During an interview on 4/4/25 at 1:25 p.m., Nursing Assistant (NA) #10 revealed the nursing assistants were required to sign up for the shower assistant team which included taking residents' dirty laundry to the laundry room.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		5/12/25

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 04/14/2025

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 637	Continued From page 21 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment for 1 of 2 sampled residents (Resident #39) reviewed for hospice services. Findings included: Resident #39 was admitted to the facility on 11/5/24 with diagnoses which included: dementia and chronic obstructive pulmonary disorder. Resident #39 was admitted to Hospice Services on 2/22/25 with the diagnosis of Alzheimer's disease with late onset. A review of the MDS assessments revealed a Significant Change in Status MDS Assessment was not completed after Resident #39 was admitted to hospice services. During an interview on 4/4/25 at 9:54 a.m., the facility's Administrator revealed the MDS Coordinator was not available. The Administrator acknowledged that a Significant Change MDS should have been completed within fourteen days of Resident #39's admission to Hospice Services.	F 637	A significant change assessment for Resident #39 and was initiated on 5/2/25 by the MDS Coordinator. Residents admitted to hospice services have the potential to be affected. An audit of residents on hospice services for the last six months was completed on 4/30/25 by the Administrator to identify any other residents with missing significant change assessments. The audit revealed no other instances of missed significant change assessments. On 5/5/25, the Regional Director of MDS provided education to the MDS Coordinators regarding the requirements and timeliness of the fourteen day look back period to complete a significant change assessment, specifically when a resident is admitted to hospice services. Newly hired MDS Coordinators will receive training by the Regional Director of MDS prior to working on the MDS. The Administrator or designee will audit newly admitted hospice residents once a month for 2 months to ensure that a significant change assessment is scheduled and completed within the	

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 04/14/2025

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 637	Continued From page 22	F 637	fourteen day look back period. The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide incontinence care to a resident upon request for 1 of 1 dependent resident reviewed for activities of daily living (ADL) (Resident #212). The findings included: Resident #212 was admitted to the facility on 3/10/25 with a diagnosis that included osteomyelitis (bone infection) and bowel and bladder incontinence due to impaired mobility. The admission Minimum Data Set dated 3/17/25 specified that Resident # 212 was cognitively intact and dependent for toileting, dressing, bathing, transfers, and mobility care. The MDS also determined that the Resident required a	F 677	Resident #212 received incontinence care on the morning of 4/1/25 after the concern was identified. Incontinent residents have the potential to be affected. An audit of incontinent residents was initiated on 4/29/25 by the Director of Nursing. Interviews with incontinent alert and oriented residents were conducted and skin assessments were completed for non-alert and oriented residents for potential skin breakdown and any identified issues or concerns were reviewed and addressed by Nursing Administration. On 4/30/25, the Staff Development Coordinator initiated education to the nursing staff regarding providing incontinence care to residents as needed	5/12/25

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 04/14/2025

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 677	Continued From page 23 mechanical lift for transfers. There were no indications of behaviors exhibited. The MDS indicated Resident #212 was frequently incontinent of bowel and bladder. Resident #212's self-care deficit care plan dated 3/13/25 indicated staff were to provide assistance with bowel and bladder incontinence related to immobility. An observation was conducted in conjunction with an interview with Resident 212 on 4/1/25 at 8:30 AM. When approaching Resident 212's room a strong odor of feces was noted. Upon entrance to Resident 212's room it was discovered the odor was coming from Resident #212's room. Resident #212 was interviewed, he stated he needed to be changed and had been waiting since before "light" (outside). Nurse Aide (NA) #1 was notified of Resident #212's request for incontinence care. An observation of incontinence care and an interview occurred with NA #1 and NA #2 on 4/01/25 at 8:40 AM. The Resident had a saturated brief with a large amount of soft stool from the front to the back and upwards. The stool was not dry and was not stuck to Resident #212's skin and the skin in his sacral area was pink and intact. The bottom sheet had stool on it, but it was not observed that the bottom sheet was wet with urine. NA #1 stated that they find him like this every time they work, and that the 11:00 PM to 7:00 AM shift "always leaves him for us to clean up." When the NAs were asked why they didn't round on the resident earlier in their shift, they stated they were not supposed to do patient care while the trays were out. NA #1 further indicated that the	F 677	and as requested to ensure the residents are clean, dry, and comfortable. Newly hired nursing staff will receive the education during orientation from the Staff Development Coordinator. Nursing staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Director of Nursing or designee will audit five incontinent residents for 4 weeks, then three residents for 2 weeks, then one resident a week for 2 weeks to ensure residents are being offered and provided timely incontinence care. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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 04/14/2025

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 677	Continued From page 24	F 677		

residents should be cleaned up and ready for breakfast by the 11:00 PM to 7:00 AM shift. She also stated the trays came out right after they got there at 7:00 AM.

On 4/01/25 at 9:06 AM, a follow-up interview with Resident #212 revealed that he turned his call light on and had asked the third shift (11:00 PM to 7:00 AM) aide, NA #5, to clean him up. He said NA #5 answered his light, turned it off, said she would return to provide incontinence care, left the room, and did not return. He said that this treatment had been going on since his admission. He further stated it was still dark outside when he rang for NA #5 but could not recall the exact time. The resident noted that the next shift (7:00 AM to 3:00 PM) came in his room but did not change him; instead, they passed out his breakfast tray around 7:00 AM, and it was light outside by this time. The resident said that NA #1 came in and told him she would get him cleaned up as soon as all the trays were passed. The resident stated he was left in his soiled brief until after the breakfast trays were passed. He said, " I can do bad at home by myself."

NA# 5 was unable to be interviewed and did not return phone calls.

An interview with the Director of Nursing (DON) on 04/04/25 at 09:45 AM revealed the staff should ensure the residents were clean and dry before the first shift. She stated that it was unacceptable for the residents to lie in soiled briefs for long periods. The DON further stated she felt the staff members understanding was to pass all trays no matter what and not to stop and clean up a resident who had not had a meal served and needed a brief change.

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 04/14/2025

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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 observations, record review and staff interviews, facility failed to secure a spray cleaner and spray deodorizer inside a housekeeping cart with a working lock for 1 of 2 housekeeping carts (the 2nd floor housekeeping cart) observed for accidents hazards. The findings included: An observation of the housekeeping cart occurred on 3/31/25 at 1:17 PM on the second floor of the facility outside of a resident's room. The side door of the cart was partially ajar. The cart did not have a lock. There were three residents seen nearby the cart. There were no staff members near the cart at the time of observation. During an observation and interview with Housekeeper #1 on 3/31/25 at 1:25 PM, she stated she had a spray cleaner, and a spray deodorizer inside the cart. Housekeeper #1 reported the cart used to have a lock but it broke sometime over the weekend (3/28/25-3/30/25). She explained she reported it to the Environmental Manager but it had not been fixed yet. Housekeeper #1 stated she was aware the	F 689	The 2nd floor housekeeping cart lock was replaced by the Maintenance Director on 3/31/25 to ensure staff could properly secure and store hazardous chemicals. Current residents have the potential to be affected. Housekeeping carts were inspected by the Maintenance Director on 3/31/25 to ensure they had functioning locks on the carts. On 4/30/25, the Staff Development Coordinator initiated education to the environmental services staff on keeping housekeeping carts locked and secured when not in use. Newly hired staff will receive the education during orientation from the Staff Development Coordinator. Staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Environmental Services Manager will audit housekeeping carts five times a week for 4 weeks, then three times a week for 2 weeks, then once a week for 2 weeks to ensure locks are working and chemicals are properly secured. The Environmental Services Managers or designee will review the data for patterns	5/12/25

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 04/14/2025

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 689	Continued From page 26 cart should have a working lock, but it was the only cart on the floor. Housekeeper #1 stated she was "keeping it close" to her as she was going from one resident's room to another. Review of the Safety Data Sheet issued 10/26/18 for the spray cleaner read, in part, "all components are considered non-hazardous and proprietary in their quantities". The SDS indicated the cleaner could cause eye irritation and to wash any contacted parts of the body after handling with soap and water thoroughly. Review of the Safety Data Sheet issued 3/6/18 for the spray deodorizer revealed it contained propanol (a colorless alcohol) and was flammable. The SDS also indicated it could cause irritation to the eyes, nose, and throat and to wash any contacted parts of the body after handling with soap and water thoroughly. During an interview with the Housekeeping Manager on 3/31/25 at 3:40 PM, he stated he had been at the facility for two weeks. The Housekeeping Manager stated he had been made aware by Housekeeper #1 that the lock had broken off over the weekend but he had not had a chance to let maintenance know yet. During an interview with the Administrator on 4/4/25 at 4:10 PM, she verbalized the importance of having a working lock on all housekeeping carts due to the cleaning chemicals stored inside.	F 689	and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		5/12/25

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 04/14/2025

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 695	Continued From page 27 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to post cautionary signage outside the resident's room to indicate supplemental oxygen (O2) was in use and to obtain a physician order for oxygen therapy for 1 of 1 resident reviewed for respiratory care (Resident #6). The findings included: Resident #6 was admitted to the facility 7/15/24 with diagnoses including chronic lung disease and hypertension. Resident #6's care plan last revised on 1/18/25 addressed potential for breathing issues related to his lung disease and specified to administer oxygen at 3 liters per minute by nasal canula. The quarterly Minimum Data Set (MDS) assessment dated 2/10/25 indicated he was cognitively intact and used oxygen therapy. Review of Resident #6's physician orders showed there was no active order for continuous oxygen therapy. Observation of Resident #6 in his room on 4/1/25 at 9:45 AM revealed he had an oxygen concentrator by his bedside delivering 3 liters of	F 695	A physician's order for continuous oxygen therapy at 3 liters per minute via nasal cannula was obtained for Resident #6 on 4/3/25. A cautionary sign was placed outside of Resident #6's room indicating supplemental oxygen was in use. An audit was conducted on 5/5/25 by the Unit Manager to identify any other residents currently receiving oxygen therapy. Residents identified were reviewed to ensure there was an active physician order in place with appropriate flow rates, and that cautionary signage was posted outside of their rooms. No other discrepancies were identified during the audit. On 5/5/25, the Staff Development Coordinator initiated education on nurses needing to obtain and maintain physician orders for oxygen therapy and to verify appropriate flow rates. Nursing staff was also re-educated on the importance of posting "Oxygen in Use" signage outside resident rooms when oxygen therapy is initiated or continued. Newly hired nursing staff will receive the education during orientation from the Staff Development Coordinator. Nursing staff that have not received the education by 5/12/25 will be unable to work until the education is	

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 04/14/2025

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 695	Continued From page 28 continuous oxygen via nasal canula. There was no cautionary signage outside of Resident #6's room indicating there was oxygen in use inside. During an interview with Resident #6 on 4/1/25 at 9:45 AM, he stated that he had been on oxygen continuously for "a while". He reported he had seen his lung specialist last week with no changes. Resident #6 reported that he saw a specialist outside of the facility who "takes care of his oxygen needs". During an interview with Nurse #2 on 4/1/25 at 10:55 AM she stated Resident #6 moved to a new room the day before (3/31/25) and the oxygen in use sign was inadvertently not moved with him. During an interview with the Director of Nursing (DON) on 4/4/25 at 2:35 PM, she stated that she was unaware Resident #6 did not have an active order for oxygen use. She stated he previously had one for as needed use but that was discontinued at the end of last year. The DON reported Resident #6 should have had a physician order entered into the facility system for continuous oxygen and that would also include instructions for the flowrate. The DON explained that initiating continuous oxygen therapy based on orders from an outside physician was appropriate, but the facility physician also needed to be notified to write an order. The DON also explained that there should be a cautionary sign on the outside of each resident's room who was on oxygen indicating there was oxygen in use.	F 695	completed. The Director of Nursing or designee will audit residents on oxygen therapy three times a week for 6 weeks, then once a week for 6 weeks to ensure there is an active physician order and proper signage is in place. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		5/12/25

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 04/14/2025

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 698	Continued From page 29 §483.25(l) Dialysis. The facility must ensure that 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain ongoing communication with the dialysis treatment center for 2 of 3 residents reviewed for dialysis (Resident #22 and Resident #11). The findings included: 1. Resident #22 was admitted to the facility on 11/19/21 with diagnoses which included end stage renal disease (ESRD) and dependence on dialysis (treatment to filter wastes and water from the blood). Resident #22 had an active physician order dated 8/21/23 for dialysis on Monday, Wednesday, and Friday. Review of Resident #22's care plan last reviewed 1/13/25 revealed the need for dialysis related to renal failure with an intervention to communicate with the dialysis center by the dialysis communication form. Review of Resident #22's electronic medical record showed completed dialysis communication forms last scanned into her chart on 11/20/24. Review of Resident #22's dialysis communication forms, located in medical records dated 11/13/24 through 3/28/25 revealed the facility was only able	F 698	The facility obtained non-uploaded dialysis records for Resident #22 and Resident #11 from their respective dialysis centers on 4/4/25, ensuring that each resident's treatment documentation was complete and current. On 5/5/25, an audit was completed for current residents receiving dialysis services. Their records were reviewed to ensure dialysis communication forms were completed. Any identified gaps were corrected by contacting the dialysis centers. On 5/5/25, the Staff Development Coordinator initiated education to nurses on completing the dialysis communication form in full prior to transport and ensuring the return portion is filled out or replaced with appropriate documentation from the dialysis center. A new binder was implemented on each nursing unit to temporarily store dialysis communication forms before they are scanned and uploaded to their charts by the Medical Records Coordinator. Newly hired nurses will receive the education during orientation from the Staff Development Coordinator. Nurses that have not received the education by 5/12/25 will be unable to work until the education is completed. Medical Records Coordinator	

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 04/14/2025

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 698	Continued From page 30 to locate 23 dialysis communications forms. Of the 23 forms located, 5 were incomplete with no documentation by the dialysis facility. There were no communication forms located for the month of December 2024. During an interview with Nurse #3 on 4/3/25 at 1:30 PM, she stated that she fills out the top part of the dialysis sheets, which included vital signs, and sends that form with the resident to her dialysis appointments. Nurse #3 then stated, she would assess the resident when she returned (vital signs and site assessment) and document the information on the resident's medication administration record. Nurse #3 reported that the dialysis center sends their own printed copy of post dialysis information instead of filling out the bottom portion of the facility provided form. Nurse #3 stated both dialysis communication papers (the partial facility and the dialysis center) go to medical records. Nurse #3 reported no dialysis sheets were kept on the floor that she was aware of. The Medical Records staff member was unavailable for interview. During an interview with the Director of Nursing (DON) on 4/4/25 at 2:08 pm she stated the facility was responsible for completing the dialysis communication form prior to the resident being sent to dialysis center and for making sure the dialysis center provides post dialysis information either by completing the bottom portion of the facility form or by providing their own printout. The DON stated she did not know why the facility had been unable to locate complete dialysis communication sheets or why they were not scanned into the chart. The DON explained it was	F 698	was educated by the Staff Development Coordinator on 5/5/25 on checking these binders on the nursing units and ensuring dialysis communication forms are scanned and uploaded timely to each resident's chart. The Director of Nursing or designee will audit dialysis communication forms three times a week for 6 weeks and then once a week for 6 weeks to ensure completeness and timely scanning. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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 04/14/2025

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 698	Continued From page 31	F 698		

the responsibility of medical records staff to scan completed dialysis communication forms into the electronic medical record.

2. Resident #11 was admitted to the facility on 8/13/24 with diagnoses which included end stage renal disease and dependence on dialysis.

Resident #11 had an active physician order dated 8/21/23 for dialysis on Monday, Wednesday, and Friday.

Review of Resident #11's care plan last reviewed 12/18/24 revealed the need for dialysis related to renal failure with an intervention to communicate with the dialysis center by the dialysis communication form.

Review of Resident #11's electronic medical record showed completed dialysis communication forms last scanned into his chart on 11/22/24.

Review of Resident #11's dialysis communication forms, located in medical records dated 11/8/24 through 3/28/25 revealed the facility was only able to locate 3 completed forms for the month of January 2025 and only 4 completed forms for the month of February 2025.

During an interview with Nurse #3 on 4/3/25 at 1:30 PM, she stated that she fills out the top part of the dialysis sheets, which included vital signs, and sends that form with the resident to her dialysis appointments. Nurse #3 then stated, she would assess the resident when she returned (vital signs and site assessment) and document the information on the resident's medication administration record. Nurse #3 reported that the dialysis center sends their own printed copy of

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 04/14/2025

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 698	Continued From page 32 post dialysis information instead of filling out the bottom portion of the facility provided form. Nurse #3 stated both dialysis communication papers (the partial facility and the dialysis center) go to medical records. Nurse #3 reported no dialysis sheets were kept on the floor that she was aware of. The Medical Records staff member was unavailable for interview. During an interview with the Director of Nursing (DON) on 4/4/25 at 2:08 pm she stated the facility was responsible for completing the dialysis communication form prior to the resident being sent to dialysis center and for making sure the dialysis center provides post dialysis information either by completing the bottom portion of the facility form or by providing their own printout. The DON stated she did not know why the facility had been unable to locate complete dialysis communication sheets or why they were not scanned into the chart. The DON explained it was the responsibility of medical records staff to scan completed dialysis communication forms into the electronic medical record.	F 698		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f)	F 791		5/12/25

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 04/14/2025

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 791	Continued From page 33 of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and resident and staff interview, the facility failed to provide dental services as ordered by the physician for 1 of 2 sampled residents (Resident #18).	F 791	On 4/4/25, the facility reviewed Resident #18's dental needs and confirmed a dental referral was not processed as ordered. Resident #18 had a dental appointment on 4/10/25 with an off-site	

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 04/14/2025

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 791	Continued From page 34 Findings included: Resident #18 was admitted to the facility on 9/5/19 diagnoses which included: COPD (chronic obstructive pulmonary disease), adult failure to thrive, diabetes mellitus, and Crohn's disease (chronic inflammatory bowel disease). Resident #18's most recent periodic oral evaluation was on 11/30/23. The oral exam showed the resident's oral tissue was red and inflamed, with heavy plaque buildup. The resident had no dental pain. The Dentist's recommendation included: dental cleaning and for the facility staff to remind/assist Resident #18 to brush her teeth twice daily, focusing at gum line. Also, dental follow-up, when needed. The review of the physician's order dated 1/29/24 documented a dental referral for Resident #18 due to a diagnosis of cavities. Review of the clinical record revealed Resident #18 was examined by the Nurse Practitioner (NP) on 3/15/24 due to a reported toothache. The examination showed the resident had cavities to several of her molars, several cracked/broken teeth, and excessive plaque. The resident's upper and lower posterior gingiva (gums) were mildly inflamed. The resulting diagnosis was oral cavity pain and poor oral hygiene. The treatment plan included: continue with (11/30/22) Tylenol (acetaminophen) as prescribed; continue (1/30/24) chlorhexidine (antiseptic) 0.12% swish and swallow; continue to (2/2/24) brush teeth twice daily and as needed; (3/15/24) Cefdinir (antibiotic) 300 mg (milligram) twice a day for seven days, refer to dentist.	F 791	dental provider. On 5/5/25, an audit of current residents with dental referrals from the last six months was completed. No other residents were found to have unaddressed dental issues. On 5/5/25, the Staff Development Coordinator initiated education for nurses to print out and give a hard copy of any outside specialty referral orders to the Director of Nursing and the Appointment Scheduler once confirmed in the electronic health record. The scheduler will then utilize an appointment referral log to fill out once referral appointments are made and will be signed off by nursing administration. Newly hired nurses will receive the education during orientation from the Staff Development Coordinator. Nursing staff that have not received the education by 5/12/25 will be unable to work until the education is completed. The Director of Nursing or designee will audit five referral orders weekly for 4 weeks, then three referral orders weekly for 4 weeks, to ensure provider referral orders are scheduled. The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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 04/14/2025

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 791	Continued From page 35	F 791		

The review of Resident #18's March 2024 physician's orders included a dental referral for a toothache dated 3/15/24.

The follow-up NP's note dated 3/19/24 revealed the cavity on the lower left side of Resident #18's mouth caused the resident to complain of pain when attempting to touch the gum area around that tooth. The dental referral was discussed along with the antibiotics for possible abscessed tooth.

There was no documentation in Resident #18's clinical record indicating the resident was referred to or seen by a dentist as re-ordered on 3/15/24. It was originally ordered on 1/29/24.

The quarterly minimum data set assessment dated 12/19/24 indicated Resident #18 was cognitively intact.

During an interview on 3/31/25 at 11:38 a.m., Resident #18 revealed she had two cavities. She stated last year, during her last dental visit, she was informed the teeth required extraction. The resident recalled that x-rays of her teeth and gums were completed but she had not received any follow-up. Resident #18 acknowledged she had no oral pain and was able to chew her food without discomfort.

A telephone interview was conducted on 4/14/25 at 10:01 a.m. with Nurse #4 who revealed she worked as the Unit Manager on the first floor but was familiar with Resident #18 who resided on the second floor in the facility. She indicated she would often see and speak with the resident, but Resident #18 did not complain of tooth or gum

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 04/14/2025

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 791	Continued From page 36	F 791		

pain. Nurse #4 explained the facility's practice was for the physician to document the medication or referral order in the que (standby) of the electronic health record for signed confirmation by a facility nurse (including a unit manager). If the physician's order was a referral order, the nurse was required to print the order then deliver the order to the Appointment Scheduler via the Scheduler's mailbox or in person. She revealed during the time period of the referral order dated 3/15/24, the physician placed the order for Resident #18 into the que of Resident #18's electronic health, then confirmed the order, herself. Nurse #4 stated that because the physician did the confirmation process, the nurses were not aware of the Resident #18's dental referral and it would not appear on the medication administration record as the medications would.

An interview with the Administrator on 4/2/25 at 3:06 p.m. revealed the facility had not had onsite dental services in six months. She further explained that if or when a resident had dental requests/needs, the resident's nurse would notify the physician who would write a referral order for dental services. The approved order would then be given to the Appointment Scheduler/Receptionist to schedule the dental appointment to an offsite dental service.

During an interview on 4/03/25 at 10:24 a.m., the Appointment Scheduler stated she maintained documentation of all referrals and scheduled appointments for three years. The nurse would inform her and give her a copy of the physician's order. She revealed Resident #18 had been seen by the dentist during previous onsite facility visits. After she reviewed documentation of Resident

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 04/14/2025

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 791	Continued From page 37 #18's referrals, the Appointment Scheduler acknowledged there were no dental referrals for this resident throughout 2024. During an interview on 4/03/25 at 10:55 a.m., the Administrator stated the nurse failed to follow through on giving the physician's dental referral order to the Appointment Scheduler. During follow-up telephone interview on 4/14/25 at 9:36 a.m., the Administrator revealed Resident #18's most recent routine on-site dental examination was on 11/30/23. She stated that after reviewing the resident's medical record, there was no documentation indicating Resident #18 complained of oral pain prior to her visit with the nurse practitioner on 3/15/24, and the resident did not complain of tooth pain during or after completion of her antibiotic treatment. The Administrator stated the routine dental on-site visit on 11/30/23 was the most recent dental examination prior to 3/15/24. The Administrator revealed the facility's practice for physician's referral orders was that once the physician entered the order for the dental referral for Resident #18 into the electronic health record, the staff nurse was to confirm the order, print the order and submit it to the Appointment Scheduler.	F 791		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		5/12/25

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 04/14/2025

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 883	Continued From page 38	F 883		

potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative

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 04/14/2025

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 883	Continued From page 39 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to offer the opportunity to be vaccinated with the Prevnar 20 (pneumococcal conjugate vaccine (PCV20) in accordance with nationally recognized standards for 4 of 5 residents reviewed for pneumococcal immunizations (Resident #16, #10, #15, and #36). Findings include: The Center for Disease Control and the Advisory Committee on Immunization Practices (ACIP), last reviewed on 10/26/24, now recommends "routine vaccination against pneumococcal infection for all adults aged 65 years or older and 19-64 with certain underlying medical conditions. Beginning June 8, 2021, for persons aged 65 years and older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown, they should receive 1 dose of PCV15 or 1 dose of PCV20." Review of the facility's immunization policy last revised in 2019 stated that all residents would be offered a pneumococcal vaccine upon admission; brand unspecified. A. Record review revealed Resident #16 was	F 883	On 5/5/25, the facility reviewed immunization records for Residents #16, #10, #15, and #36. Each resident and/or responsible party was notified and provided education regarding the updated Center for Disease Control recommendation for Prevnar 20. Consent or refusal was documented for each resident, and vaccination was offered or administered as consented. The Infection Preventionist initiated an audit on 5/5/25 to see which residents were up to date per CDC and the Advisory Committee on Immunization Practices guidelines. Those who were not up to date were offered the Prevnar 20 vaccination and their consent or refusal was documented in the electronic medical record system. On 5/5/25, the Regional Clinical Nurse educated the Director of Nursing and Infection Preventionist on the updated CDC ACIP protocol and proper documentation practices for pneumococcal vaccinations. To ensure ongoing compliance, the Infection Preventionist or designee will complete weekly audits of new admissions for proper pneumococcal vaccine documentation for eight weeks.	

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 04/14/2025

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 883	Continued From page 40 admitted to the facility on 8/24/2018 and was over 65 years of age at the time of admission. Review of the pneumococcal immunizations, provided by the facility, indicated Resident #16 received a pneumococcal PPSV23 vaccine on 10/28/24. There was no documentation that the resident received a PCV20 vaccine prior to admission or since the last recertification on 11/16/2023. B. Record review revealed Resident #10 was admitted to the facility on 3/5/2024 and was over 65 years of age at the time of admission. Review of the pneumococcal immunizations, provided by the facility, indicated Resident #10 declined to receive a pneumococcal PPSV23 vaccine. There was no documentation on the declination form that the resident had specifically been offered a PCV20 vaccine. There was no documentation that the resident received a PCV20 vaccine prior to admission or since the last recertification on 11/16/2023. C. Record review revealed Resident #15 was admitted to the facility on 4/20/2022 and was over the age of 65. Review of the pneumococcal immunizations, provided by the facility, indicated Resident #15 declined to receive a pneumococcal PPSV23 vaccine. There was no documentation on the declination form that the resident had specifically been offered a PCV20 vaccine since the last recertification on 11/16/2023. There was no documentation that the resident received a PCV20 vaccine prior to admission.	F 883	The Infection Preventionist or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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 04/14/2025

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 883	Continued From page 41	F 883		

D. Record review revealed Resident #36 was admitted to the facility on 7/13/2023 and was over 65 years of age at the time of admission.

Review of the pneumococcal immunizations, provided by the facility, indicated Resident #36 declined to receive a pneumococcal PPSV23 vaccine. There was no documentation on the declination form that the resident had specifically been offered a PCV20 vaccine since the last recertification on 11/16/2023. There was no documentation that the resident received a PCV20 vaccine prior to admission.

During an interview with the Staff Development Coordinator/Infection Preventionist (IP) on 4/4/2025 at 10:05 AM, she stated that the facility offers PPSV23 (Pneumovax 23) to all residents. The IP stated that, as far as she was aware of, the facility had never offered the Prevnar 20 vaccine. The IP reported she was not aware of the regulation that stated the facility should follow the ACIP recommendations.

During an interview with the Director of Nursing on 4/4/2025 at 3:00 PM, she reported the facility offered the pneumococcal PPSV23 vaccine to all residents upon admission and she was unaware that the facility also needed to offer the Prevnar 20 vaccine.