STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335125	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Rehabilitation & Nursing Care Center	660 Louisiana Ave Brooklyn, NY 11239

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interviews during a survey, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice. This was evident for one (1) out of three (3) sample residents (Resident #1) reviewed for nutrition and hydration. Specifically, Resident #1 with history of poor oral intake had no documented oral intake from 03/14/2026 at 8:00 AM through 03/16/2026 at 1:00 PM was not assessed by Registered Nurse to prevent complication. Additionally, the medical doctor was not notified until 03/16/2026 at 3:44 PM after Registered Nurse Supervisor #2's assessment due to Resident #1 change in mental status and was rapidly declining. The findings are: The facility policy titled Meal Consumption with a reviewed date 08/2025 documented the facility will ensure that each resident receives adequate nutrition to maintain health, prevent weight loss, and support overall well-being. Staff will monitor, assist, accurately document meal consumption and promptly intervene when intake is inadequate. Certified Nursing Assistant will document intake percentage for each meal, record refusals and resident behaviors and report poor intake promptly. If a resident consumes less than 50 percent of meals, staff must report to nurse immediately. The nurse's responsibilities will review intake documentation daily, assess resident with poor intake, document interventions and outcomes, notify medical doctor/provider as indicated and ensure care plan reflects nutritional needs. The Medical Doctor /Provider will be notified when meal intake is consistently less than 50 percent, significant decline in intake is observed, weight loss occurs, and residents refuse meals repeatedly. Resident #1 was admitted to the facility with diagnoses including dementia with declining mental and functional status, and pulmonary venous congestion (abnormal accumulation of fluid in the lungs' blood vessels).The Minimum Data Set (a resident assessment tool) dated 03/08/2026, documented Resident #1 had severely impaired cognition and required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating. A dietary care plan for hydration/fluid maintenance dated 02/13/2026 documented Resident #1 was at risk for dehydration due to dementia and varied oral intake. Interventions included will observe for signs and symptoms of dehydration and explore potential reasons for decreased oral intake such as swallowing problems, mouth pain and depression.A review of the physician's order dated 02/13/2026 documented Resident #1 was on no added salt mechanical soft diet with thin liquids and diet was downgraded to puree solids on 03/12/2026 per speech therapist recommendation.A review of the Resident Certified Nursing Assistant Documentation History Detail revealed Resident #1 had no oral intake from 03/14/26 8:00 AM-9:00 AM through 03/16/2026 12:00 PM-1:00 PM. A total of 8 meals were missed.There was no care plan documented for Resident #1 regarding refusal of meals or poor appetite.There was no documentation that the Medical Doctor or Registered Nurse were notified until 03/16/2026 at 3:44 PM when Registered Nurse Supervisor #2 documented Resident #1 was assessed and had a change in mental status and was rapidly declining. A review of nursing notes dated 03/16/2026 at 3:44 PM by Registered Nurse Supervisor #2 documented Resident #1 with change in mental status. Resident #1 has been rapidly declining. Resident #1 was assessed noted weak, lethargic (feeling very tired, sluggish or lacking energy), and only responsive to tactile stimuli. Resident #1 has not been eating and spitting up brown secretions (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from mouth. Medical Doctor #1 was notified and ordered to start intravenous fluids for three (3) days, complete blood count, comprehensive metabolic panel, urine analysis and culture and sensitivity tests. Resident #1 was seen later by Medical Doctor #1 at bedside and ordered to send Resident #1 to emergency room.A review of medical notes dated 03/16/2026 at 7:34 PM by Medical Doctor #1 documented Resident #1 was weak, lethargic, shaky with heavy breathing, not alert but obtunded (diminished responsiveness to stimuli) , pale color. Ordered laboratory work ups, started intravenous fluids, 1-gram Rocephin given but was not improving. Ordered to send to emergency room as they became unstable due to altered mental status.During an interview on 03/23/2026 at 11:46 AM, Certified Nursing Assistant #1 stated they were the regular staff assigned to Resident #1. Certified Nursing Assistant #1 stated Resident #1 had history of not eating well. Certified Nursing Assistant #1 stated Resident #1 had behavior of being combative during care and when feeding them they would take two (2) spoonful and take a few sips of fluids and then Resident #1 would push away the tray. Certified Nursing Assistant #1 stated not all the time Resident #1 refuses to eat or drink but there were times when they would eat 25 percent to 75 percent of their meals. Certified Nursing Assistant #1 stated they worked on 03/14/2026 to 03/15/2026 from 7:00 AM to 3:00 PM shift and they documented zero 0 percent in eating because Resident #1 did not eat their meals. Certified Nursing Assistant #1 stated they offered fluids to Resident #1 but did not document. Certified Nursing Assistant #1 stated they did not report to Licensed Practical Nurse #1 because they knew that Resident #1 had not been eating and refused to eat.During an interview on 03/24/2026 at 4:45 PM, Certified Nursing Assistant #2 stated they were assigned to Resident #1 on 03/14/2026 and 03/15/2026 from 3:00 PM to 11:00 PM shift. Certified Nursing Assistant #2 stated they were aware that Resident #1 had poor appetite, and the family comes to visit and brings food for Resident #1 to encourage them to eat. Certified Nursing Assistant #2 stated on 03/14/2026 and 03/15/2026 in the evening shift they documented zero (0) percent for food consumption because Resident #1 refuses to eat. Certified Nursing Assistant #2 stated they offered juice to Resident #1 and took it but did not document the fluid consumption. Certified Nursing Assistant #2 stated they were supposed to report to Licensed Practical Nurse #1 when Resident #1 did not eat.During an interview on 03/24/2026 at 5:10 PM, Licensed Practical Nurse #1 stated they worked on 03/14/2026 from 7:00 AM to 11:00 PM and on 03/15/2026 from 3:00 PM to 11:00 PM. Licensed Practical Nurse #1 stated they did not receive report from their staff that Resident #1 did not eat or drink in their shift. Licensed Practical Nurse #1 stated they offered and provided oral fluids to Resident #1 when they give medications to them. Licensed Practical Nurse #1 stated if they knew that Resident #1 did not eat anything at breakfast or lunch or dinner, they would encourage Resident #1 to eat and drink, and they will report to their supervisor. Licensed Practical Nurse #1 stated they did their rounds during meal times, and they did not observed Resident #1 not eating. Licensed Practical Nurse #1 stated they did not observed Resident #1 weak or less responsive in their shift.During an interview on 03/30/2026 at 10:54 AM, Licensed Practical Nurse #2 stated they worked on 03/15/2026 from 7:00AM-3:00 PM shift. Licensed Practical Nurse #2 stated staff did not report to them that Resident #1 did not eat breakfast or lunch. Licensed Practical Nurse #2 stated if they received report, they would notify their supervisor. Licensed Practical Nurse #2 stated they gave medications to Resident #1 with no problem. Licensed Practical Nurse #1 stated on 03/15/2026, Resident #1's family member #1 was at their bedside encouraging them to drink and they assisted them in giving the supplement and Resident #1 drank some of it.During an interview on 03/30/2026 at 11:14 AM, Registered Nurse Supervisor #1 stated they worked on 03/14/2026 and 03/15/2026 from 8:00 AM to 4:00 PM. Registered Nurse Supervisor #1 stated they did not receive any report that Resident #1 had poor appetite or did not eat on both days. Registered Nurse Supervisor #1 stated the Certified Nursing Assistant should notify the unit nurse when Resident #1 refused or did not eat anything and they will notify the medical doctor. Registered Nurse Supervisor #1 stated if they reported to them, they would come and observe Resident #1's eating and continue to offer their supplement. Registered Nurse Supervisor #1 stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse manager on the unit are responsible for running the report to check the certified nursing assistant's documentation. During an interview on 03/23/2026 at 1:01 PM, Registered Nurse Supervisor #2 stated they were the unit manager where Resident #1 resided. Registered Nurse Supervisor #2 stated they knew Resident #1 had history of poor appetite, combative behavior, at times refuses medications or meals and they addressed them in their care plan meeting on 02/25/2026. Registered Nurse Supervisor #2 stated the Health Care Proxy and Adult Sibling #1 were very involved with Resident #1's care. Registered Nurse Supervisor #2 stated they reviewed the 24-hour report on 03/16/2026, and they did not observed Resident #1 in the report for any unusual changes in their condition or for not eating. Registered Nurse Supervisor #2 stated they are responsible for checking the completeness of documentation for their staff but unable to see the percentage of oral intake of Resident #1. Registered Nurse Supervisor #2 stated they observed Resident #1 ?s sudden change in condition on 03/16/2026 (unsure of time) and they notified the medical doctor immediately and health care proxy. During an interview on 03/24/2026 at 5:20 PM, Director of Nursing stated the change in Resident #1's condition was sudden, and the facility took immediate action on 03/16/2026 until the medical doctor decided to transfer Resident #1 to the hospital. Director of Nursing stated that as they are reviewing the certified nursing assistant's documentation for the month of March for Resident #1 in eating, they observed from 03/13/2026 of 4:00 PM, Resident #1 had zero (0) percent eaten until 03/16/2026 of 1:00 PM. Director of Nursing stated they were not aware that some staff were not documenting the fluid consumption as well taken by Resident #1. Director of Nursing stated the staff should have reported to the unit nurses when Resident #1 did not eat or refused to eat. Director of Nursing stated the unit managers were responsible in running the certified nursing assistant's documentation to ensure the completeness of care provided but unable to view the percentage of how much Resident #1 ate. Director of Nursing stated they taught the unit managers to run the report to check the eating/fluid consumption to prevent the recurrence of the incident. Director of Nursing stated they followed up Resident #1 in the hospital and they said they admitted them but did not provide them with diagnosis.During an interview on 03/30/2026 at 12:28 PM, Medical Doctor #1 stated they last examined Resident #1 on 03/13/2026 and documented Resident #1 was eating well. Medical Doctor #1 stated they did not receive a call on 03/15/2026 that Resident #1 was not eating or drinking. Medical Doctor #1 stated if they notified them, they would start an intravenous fluid for hydration and blood work up. Medical Doctor #1 stated they notified them of change in condition on 03/16/2026 (unsure of time) and examined Resident #1. Medical Doctor #1 stated the sudden decline in Resident #1's condition was not the result of Resident #1's not eating but because there were other underlying conditions. 10 New York Codes, Rules, and Regulations 415.12