STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365101	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Nursing and Rehabilitation Center LLC	401 N Broadway St Green Springs, OH 44836

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on medical record review, review of facility incident investigations with witness statements, review of staff education, staff interviews, review of a resident handbook, review of a facility Self-Reported Incident (SRI), and review of facility smoking policies, the facility failed to ensure Resident #75 who had a known history of smoking with oxygen on, was assessed as an independent smoker, exhibited safe smoking practices and did not smoke while wearing oxygen. This resulted in Immediate Jeopardy and serious life-threatening harm, injuries and/or death when Resident #75 lit a cigarette while wearing oxygen therapy via nasal cannula, in the designated smoking area. Resident #75's oxygen ignited and set Resident #75 on fire with the oxygen. Resident #75 sustained singed facial hair, and the skin around his mouth, nose, and bilateral cheeks was charred black. Resident #75, while being treated by the local emergency medical squad, began to experience a deteriorating airway and adventitious lung sounds (respiratory noises beyond that of normal breath sounds) that were identified as stridor (high-pitched wheezing sound caused by disrupted airflow due to obstruction of the upper respiratory tract). Resident #75 was life flighted to a burn hospital and subsequently passed away approximately eight hours later from smoke inhalation and thermal burns. This affected one (Resident #75) of three residents reviewed for smoking and who utilize oxygen therapy. The facility identified 11 residents (#01, #04, #07, #13, #20, #26, #31, #32, #41, #49, and #71) who smoke independently and six residents (#12, #17, #27, #57, #63, and #73) who require supervision with smoking. The facility identified Resident #17 and #26 who smoke and who utilize supplemental oxygen. The facility census was 73. On [DATE] at 3:32 P.M., the Administrator and the Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at approximately 2:15 A.M., when State tested Nurse Aide (STNA) #14 observed a weird flash of light from the smoking area and ran out to the area. Resident #75 was on fire in the smoking area and the oxygen tubing was on fire. STNA #14 yelled the resident was on fire, grabbed the tubing and disconnected it from the oxygen cylinder. Resident #75 was alert and oriented and was observed to have singed facial hair, and the skin around his mouth, nose, and bilateral cheeks was charred black. Licensed Practical Nurse (LPN) #401 arrived and instructed STNA #14 to call emergency services. Upon emergency squad arrival, Resident #75 was assessed to have deteriorating lungs sounds with stridor (a harsh noise when breathing, caused by obstruction of the windpipe). Air transport was completed from the facility to the burn hospital where Resident #75 died from smoke inhalation and thermal burns at 10:44 A.M. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 2:15 A.M., facility staff witnessed Resident #75's oxygen ignite while smoking in the facility smoking area, extinguished the fire and called for emergency services. On [DATE] at 9:00 A.M., the Interdisciplinary Team (IDT) met and reviewed the facility smoking policy and discussed a possible smoking area closure, but no changes were made at this time. On [DATE], an SRI was submitted to the Ohio Department of Health. On [DATE], the Administrator individually met with 15 alert and oriented residents (Resident #01, Resident #04, Resident #07, Resident #12, Resident #13, Resident #17, Resident #20, Resident #26, Resident #27, Resident #31, Resident #32, Resident #41, Resident #49, Resident #57, and Resident #63) who smoke, and provided education on the smoking policy and safety, including with oxygen. On [DATE], the Administrator met with families of residents in the smoking area to educate them on the smoking policy and safety. On [DATE] and [DATE], the DON and Nursing Facility Registered Nurse (NFRN) #7000 completed smoking assessments on all residents who smoke. There were no additional residents who were identified to smoke and utilize oxygen. At this time, care plans were reviewed on all residents who smoke. The care plans for Residents #17, #26 and #75 were updated to be supervised smokers, and all Kardex's were updated. On [DATE], the facility smoking assessment form was revised to reflect residents who smoke and utilize oxygen will require supervision for smoking and retired the previous smoking assessment utilized by the facility. Review of the new smoking assessment form revealed all residents who smoke and use oxygen now require supervision to smoke. On [DATE], nursing supervisors were notified and educated of the change to the smoking assessment form by the DON and nursing education on the new assessment for was initiated. On [DATE] through [DATE], the occupational therapy (OT) department evaluated all smokers for dexterity and speech therapy (ST), in conjunction with nursing, evaluated all smokers for cognition. The results of these evaluations were reviewed by the DON and NFRN #7000 and no changes in care plans were needed. Review of the assessments revealed all smokers were re-assessed. On [DATE], all residents were notified of the smoking area time changes via a letter from the Administrator. Facility staff were notified via the mass messaging application GreyMAR (a messaging system utilized by the facility to disseminate communication to staff which also shows acknowledgement of receipt of message) by the Administrator. This message stated, Effective immediately, the smoking area outside 1 South will be closed from 11p-6a to everyone. Please make sure the doors are closed. We will monitor the cameras to make sure we are in compliance. This is for resident safety. Please see Administrator if you have any questions. Thank you. On [DATE], the smoking policy, safety of not smoking with oxygen, and updated smoke area times are discussed in the Resident Council Meeting by Director of Activities #31. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the Administrator educated independent smokers on the closure of the smoking area from 11:00 P.M. to 6:00 A.M. for supervised smokers. The Administrator provided staff education on this closure via the GreyMAR messaging system. This message stated, As of today, the smoking area will be closed to supervised smokers from 11 P.M. - 6 A.M. Independent smokers can utilize the smoking area. The independent smokers have been educated to use the doorbell when needed as well. If questions, please see Administrator. Thank you. At this time, education was also initiated individually with staff. On [DATE], the DON placed the facility's updated smoking safety education on Clipboard (a website education platform utilized by agency staff). On [DATE], the facility began audits to monitor smoking safety that will be conducted two times per shift, four times per week, for four weeks. After that time, the audits will continue one time per shift, four times per week, for four weeks. After that time, audits will continue one time per shift, three times per week, for four weeks. After that time, audits will continue monthly for three months. The audits will be completed by the DON or designee and reviewed at the facilities monthly Quality Assurance and Performance Improvement (QAPI) meetings, which are held on the third Wednesday of each month. Review of the audit form revealed the facility began conducting the audits to monitor smoking safety on [DATE] and continued them on [DATE]. On [DATE], the facility finalized updating the facility smoking policy as well as updated the facility handbook to reflect smoking changes along with the updated policy. On [DATE], the activities department ensured all residents were provided with copies of the new handbook and received their signatures. On [DATE], the Administrator provided staff education on the updated smoking policy to staff via the GreyMAR messaging system. This message stated, The updated resident smoking policy is posted at the time clocks. Please review and let me know if you have any questions. Thank you. Review of the GreyMAR system revealed staff acknowledge completion of education with a check mark by their name. On [DATE], the DON placed the facilities updated smoking safety education on Clipboard (a website education platform utilized by agency staff). Agency staff acknowledge reading prior to taking an assignment at the facility. Interviews on [DATE] between 10:00 A.M. and 3:30 P.M., with Certified Occupational Therapy Assistant #44, Certified Medication Aide #302, Hospitality Aide #300, and Registered Nurse #36, revealed they were educated regarding the facility smoking policy after the incident took place with Resident #75, the changes to the facility smoking policy, and verified they were knowledgeable regarding the education provided to them. Review of Resident #17 and #26's medical records revealed they both were smokers who utilized oxygen therapy. Both residents had been evaluated by OT and the new smoking evaluation/assessment had been completed. Both residents were now supervised for smoking. Care plans and Kardex's were updated to reflect the supervision required due to oxygen usage. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of Resident #75's closed medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, personal history of COVID-19, anxiety, atherosclerotic heart disease, type two diabetes mellitus, anemia, dementia, elevated white blood cells, hypo-osmolality, dermatitis, hyperlipidemia, vitamin D deficiency, nicotine dependence, and alpha 1 antitrypsin deficiency. Review of the most recent quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact and required assistance with oral hygiene, toileting, shower/bathing self, lower body dressing, putting on/taking off footwear, personal hygiene, standing from a sitting position, chair transferring, toileting transferring, transferring from the tub/shower, and walking 10 feet. Review of the social services progress note dated [DATE] at 12:20 P.M., revealed the Administrator/Licensed Social Worker (LSW), who acts as both, met with the resident and educated him on the facility smoking policy. Resident #75 stated he understood safety protocol for taking off oxygen, if he goes to the smoking area. He stated he had a problem in the past at home while trying to smoke with his oxygen on, so he knows the importance of turning it off and removing the tubing. Review of a nursing note dated [DATE] at 2:28 P.M. revealed writer, [Registered Nurse (RN) #36], noted the resident to be outside smoking. Writer advised resident of smoking with oxygen risks and informed him of the danger to himself and others. Resident #75 extinguished his cigarette and was upset stating that he knew what he was doing and didn ' t need to be told of the dangers as he has already blown himself up once. Writer notified the DON. The DON went to speak with the resident. Review of a nursing note with an effective date of [DATE] at 3:02 P.M., (with a late entry date created of [DATE] at 2:47 P.M.) by the DON, revealed spoke with Resident #75 at this time regarding smoking policy and safety. Resident #75 states he is aware of the safety measures due to a previous incident while at home. Educated on safety again for self and other residents. Resident #75 states he is aware and understands. Agreeable to policy and plan. Very respectful towards writer during conversation. Will continue plan of care (POC). Review of the Smoking Safety Screen dated [DATE] revealed Resident #75 did not have cognitive loss, had no visual deficits, had no dexterity problems, smokes ,d+[DATE] cigarettes per day, likes to smoke in the afternoon and evening, is able to light his own cigarette, needs the facility to store his lighter and cigarettes, the plan of care is used to assure the resident is safe while smoking, the resident is able to turn off O2 support, verbalized safe smoke rules, and utilized smoking receptacles. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Smoking Safety Screen dated [DATE] revealed Resident #75 did not have cognitive loss, had no visual deficits, smokes ,d+[DATE] cigarettes per day, likes to smoke in the afternoon and evening, is able to light his own cigarette, supervision, needs the facility to store his lighter and cigarettes, the plan of care is used to assure the resident is safe while smoking, notes on safety from interdisciplinary team conference (IDTC) revealed Resident #75 needs supervision for smoking due to cognition and use of oxygen and the team decision is the resident is safe to smoke with supervision. Review of the Smoking Safety Screen dated [DATE] revealed Resident #75 did not have cognitive loss, had no visual deficits, had no dexterity problems, smokes ,d+[DATE] cigarettes per day, likes to smoke in the afternoon and evening, is able to light his own cigarette, needs the facility to store his lighter and cigarettes, the plan of care is used to assure the resident is safe while smoking, the resident is able to turn off O2 support, verbalized safe smoke rules, and utilized smoking receptacles. Review of the care plan for smoking dated [DATE] revealed Resident #75 was safe to smoke unsupervised. The goal is listed as resident will have no injury or decline related to smoking through review. The interventions are listed as educate as needed related to risks associated to smoking, educate/remind not to smoke with O2 (oxygen), and safe to smoke unsupervised. Review of a nurse progress note dated [DATE] at 10:27 A.M., revealed another resident alerted writer that he (Resident #75) was smoking with O2 (oxygen) on, writer notes he is outside at smoking area with a cigarette but not lit. Educated him that he can (later confirmed as a clerical error during an interview with LPN #304 which should have been documented as can ' t) smoke while O2 is on, and he states he knows that and is not smoking. Advised him he should not be in the smoking area while O2 is on, while other people are smoking either; he states he is aware of this and returned to his unit at this time. Review of the social service note dated [DATE] at 2:36 P.M., revealed the Administrator/LSW (who acts as both) met with the resident and re-educated him on the smoking policy and process. He acknowledged understanding. Review of the Smoking Safety Screen dated [DATE] revealed Resident #75 did not have cognitive loss, had no visual deficits, had no dexterity problems, smokes more than 10 cigarettes per day, likes to smoke at all times during the day, can relight their own cigarette, needs the facility to store their lighter and cigarettes, the plan of care is used to assure the resident is safe while smoking, is able to turn off O2 support, and verbalized safe smoke rules and utilized smoking receptacles. Resident #75 was assessed as a safe smoker and able to smoke independently. Review of the nursing note dated [DATE] at 3:11 A.M., revealed Resident #75 came to the nursing station at 2:00 A.M. and asked for a new oxygen tank. He stated his old tank was running low, so this nurse changed client's oxygen tank, client was stable, and he wheeled away in his power chair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the written witness statement from State tested Nursing Assistant (STNA) #14, dated [DATE], revealed at 2:10 A.M., she was standing at the 1 south nurses station copy machine making copies when she happened to see a light and looked outside to see Resident #75 outside swiping at his face to get his oxygen cord away from his face that was on fire. STNA #14 and her hall partner (STNA #91), and Licensed Practical Nurse (LPN) #401, all ran out the doors to help. When STNA #14 got outside she grabbed the cord and ripped it from his oxygen tank and put the fire out, then took the tank and shut it off and took it away from the scene. At that time STNA #91 called 911 at 2:15 A.M. Review of the written witness statement from LPN #58, dated [DATE] at 2:33 P.M., revealed she was notified of this incident at approximately 2:20 A.M., when STNA #329 came to the third floor and notified LPN #58 of a smoking related incident on the first floor, outside, in the resident smoking area, and that 911 had been called. LPN #58 observed Resident #75 sitting upright in his power wheelchair, sitting next to the picnic table with STNA #91 standing next to him. LPN #58 observed Resident #75's facial hair was singed, and his skin was black around his upper lip, nose, and bilateral cheeks. Resident #75 had oxygen tubing in his hand. LPN #58 asked Resident #75 what happened, and he stated, I don ' t know what happened. Resident #75 was A&O (alert and oriented) to name and place. Resident #75 knew who LPN #58 was and stated her name. LPN #58 applied cold, wet cloths to Resident #75's face and took Resident #75's SpO2 (blood oxygen concentration reading) and it measured 77 percent (%), and respirations were 22 (breaths per minute). Oxygen was applied to resident, via NC (nasal canula: a device that delivers extra oxygen through a tube and into the nose), as ordered. At this time EMS (emergency medical services) arrived. The 1 south nurse took the rest of the VS (vital signs) in residents left arm. EMS workers were assessing resident subjectivity at this time, and resident stood up out of his wheelchair, sat down on the gurney, and was put into the ambulance by EMS workers. Review of the written witness statement from STNA #91, dated [DATE], revealed STNA #14 noticed Resident #75 was on fire in the smoking area. She first noticed what looked like a weird flash of light. After taking a second look, STNA #14 noticed his oxygen tubing was on fire. STNA #14 yelled he (Resident #75) is on fire. STNA #91, STNA #14, and LPN #401 went running outside. STNA #14 grabbed the tubing and disconnected it from the oxygen cylinder. Also, putting out the fire. STNA #91 stayed with Resident #75 until his nurse came. Resident #75's nurse had her call 911. This was at 2:15 A.M. The squad came. Review of the written witness statement from LPN #401, dated [DATE], revealed they were alerted on [DATE] at approximately 2:10 A.M., that Resident #75 was outside in the smoking area and there was a bright light outside near Resident #75. When LPN #401, STNA #14, STNA #91, and STNA #329 arrived in the smoking area, they noticed the oxygen tubing was on fire. The aide removed the oxygen tubing, turned O2 off, and put out the fire. Emergency 911 was called at 2:15 A.M. LPN #401, STNA #14, STNA #91, STNA #329, and LPN #58 stayed with Resident #75 until the resident was put onto the stretcher by EMTs (emergency medical technicians), who stated they were taking the resident to the local hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the County Emergency Medical Service (EMS) documentation revealed they received notification of this incident at 2:16 A.M., and an advanced life support (ALS) squad was dispatched. The ALS squad arrived at the facility at 2:24 A.M., with one driver, one advanced emergency medical technician (AEMT), and two paramedics. Upon their arrival, Resident #75 was noted to have signs of charring on the face with a nasal cannula in the mouth. The initial EMS assessment of Resident #75 noted the majority of his face was charred, and his nasal cavity (the inside of the nose) was black with no nasal hair present. Once transported from the smoking area, where the incident occurred, to the ambulance, intravenous (IV) access was obtained, and Resident #75 was placed on a non-rebreather mask (a face mask to supply a more concentrated level of supplemental Oxygen) at 15 liters per minute. Review of the facility electronic medical record revealed Resident #75 utilized three liters of supplemental Oxygen via a nasal cannula at baseline. After obtaining IV access, County EMS contacted Life Flight for air transport to St. Vincent's Hospital in [NAME], Ohio as Resident #75 was noted to have a deteriorating airway and adventitious lung sounds (respiratory noises beyond that of normal breath sounds) that were identified as stridor (high-pitched wheezing sound caused by disrupted airflow due to obstruction of the upper respiratory tract). Upon their arrival, intraosseous (IO) access (a procedure that involves inserting hollow needle into a bone's marrow cavity to deliver fluids and medications) was obtained in Resident #75 and the Life Flight crew was able to intubate (insert a tube through the mouth and into the airway to aid with breathing) utilizing rapid sequence intubation (an airway management technique that produces immediate unresponsiveness and muscular relaxation). At this time, Resident #75 was ventilated utilizing a bag valve mask (BVM), transferred from the ambulance to the helicopter, and transported via helicopter to St. Vincent's Hospital. Review of the death certificate revealed Resident #75 expired on [DATE] at 10:44 A.M. and listed the immediate cause of death as smoke inhalation and thermal burns, with a description of how the injury occurred as ignited self-smoking while using oxygen supplementation. Interview on [DATE] at 10:15 A.M. with the DON revealed that on [DATE] Resident #75 requested a new Oxygen tank from staff and then went outside to smoke. On [DATE] at approximately 2:10 A.M., Resident #75 lit a cigarette and ignited his oxygen, and he was burned as a result. Interview on [DATE] at approximately 8:00 A.M. with the Administrator revealed the facility was aware of the history of an incident involving Resident #75 smoking while wearing Oxygen prior to his admission to the facility. Interview on [DATE] at 8:55 A.M. with the Administrator revealed Resident #75 had expressed that he had a history of smoking with oxygen on. Resident #75 knew the policy and he was encouraged to follow the smoking policy. The Administrator stated she did not feel Resident #75 was having an issue with smoking with his oxygen on. Facility staff would check on Resident #75 periodically and his oxygen was never turned on during these checks. Sometimes other residents would report concerns that Resident #75 was smoking with his oxygen on, but when the facility investigated these reports, they were never validated. Interview on [DATE] at 9:15 A.M. with LPN #304 revealed the word can in the progress note dated [DATE] was a clerical error that was not realized until the Ohio Department of Health (ODH) entered the facility for the survey. LPN #304 stated it should have been can ' t. At this time, LPN #304 was advised by administration to not change her documentation during the complaint investigation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 9:53 A.M. with the DON revealed the facility did not know Resident #75 had a history of smoking with oxygen turned on at home. The care plan for Resident #75 was written for Resident #75 based upon his assessment while he was in the facility. The [NAME] verified the care plan did not address the storage of the smoking materials. The DON stated the IDT team met on [DATE] due to the resident having a urinary tract infection and made him a supervised smoker. They met again on [DATE], when the urinary tract infection was gone, he was re-assessed and made an independent smoker. The DON stated sometimes Resident #75 kept his own smoking materials and sometimes the facility kept them. According to the policy, he can store them, but if the family brings in a large quantity of cigarettes, the facility will store the excess. When the facility was bought by a new owner, the policy was re-evaluated, and things were updated. The assessments couldn't be re-assessed and changed because the facility didn ' t have access to change it in the electronic medical record system for a while. Interview on [DATE] at 9:52 A.M., with the DON revealed the Smoking Safety Screens performed on [DATE] and [DATE], were performed four days apart as the resident had a urinary tract infection (UTI) on [DATE] and had decreased cognition and those cognition issues had resolved on [DATE]. Interviews with witnesses to the [DATE] incident with Resident #75 were attempted multiple times from [DATE] to [DATE] but were unsuccessful. Review of the policy titled, Smoking Policy-Residents, revised [DATE], revealed the facility shall establish and maintain safe resident smoking practices. Oxygen use is prohibited in smoking areas. Residents are not permitted to give smoking articles to other residents. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision. Review of the policy titled, Smoking policy revised [DATE], revealed oxygen use is prohibited in smoking areas. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include current level of tobacco consumption, method of tobacco consumption, desire to quit smoking if a current smoker, and ability to smoke safely with or without supervision, and oxygen prescription. The staff shall consult with the attending physician and the DON. Services to determine if safety restrictions need to be placed on a resident's smoking privleges are based on the Safe Smoking Evaluation. Review of the undated resident handbook stated that adherance to the smoking policy is necessary to provide a safe and healthy enviroment. The designated smoke area will be closed from 11 PM-6AM daily for supervised smokers. This deficiency represents non-compliance investigated under Complaint Number OH00157190.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 49742 Based on review of the facility's billing statements, review of email communication, vendor interviews, and staff interviews, the facility failed to operate the facility in a manner to ensure facility bills were being paid in a timely manner. This had the potential to affect all 73 residents in a facility with a census of 73. Findings include: 1. Review of the facility's electric invoice dated 07/29/24 revealed an amount of $438,869.15 was due by 09/19/24 with a disconnection notice provided which states the facility's electric service payment is past due and the electric service could be disconnected unless payment of $409,334.97 is made by 08/19/24. Review of the facility's electric invoice dated 08/30/24 revealed an amount of $436,010.41 was due by 09/20/24 with a disconnection notice provided which stated the facility's electric service is payment is past due and the electric service could be disconnected unless payment of $403,795.52 is made by 09/20/24. Review of the facility's payments to the electric service provider revealed payments in the amount of $25,000 on 03/20/24, 05/03/24, 07/25/24, and 08/23/24. Concurrent review of the facility's payments to the electric service provider revealed there were no payments made to the electric service provider in the months of April, June, and September 2024. Interview on 09/09/24 at 4:12 P.M., with Administrator verified there have been no payments made the facility's electric service provider in the months of April, June, and September 2024. Interview on 09/11/24 at 8:08 A.M., with Electric Provider Customer Service Agent, Electric Company Employee #55919, revealed the service provider is unable to provide an installment plan for repayment at this time and $403,795.52 will need to be paid by 09/20/24 to avoid a service disconnection. Telephone interview on 09/11/24 at 12:23 P.M., with Owner #500 revealed they have been working on a payment arrangement with a revenue operations supervisor at the electric service provider and reach a new payment arrangement. Prior to the new arrangement, the facility and the electric service provider agreed on payments in the amount of $25,000 per month. The new payment arrangement agreed upon by the facility and the electric service provider is $35,000 paid every two weeks until 10/20/24 when 25% of the balance (approximately $125,000) will be paid. Upon receipt of the $125,000 on or before 10/20/24. Owner #500 and the revenue operations supervisor at the electric service provider will meet to establish an amicable payment arrangement for the remainder of the account balance. Review on 09/11/24 at 2:05 P.M. of a signed agreement letter dated 09/11/24, between Owner #500 and the revenue operations supervisor for the electric service provider verified the current repayment agreement between the facility and the electric service provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365101	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Nursing and Rehabilitation Center LLC	401 N Broadway St Green Springs, OH 44836

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 09/18/24 at 10:37 A.M., of the facility provided list of residents who are ventilator dependent revealed eight residents (#02, #22, #40, #45, #47, #55, #61, and #64). Interview on 09/18/24 at 11:42 A.M., with the Administrator revealed all residents utilized the electricity and the eight listed depend on a ventilator for life support. 2. Review of the facility's medical equipment supplier invoice dated 08/31/24 revealed an amount of $59,597. 49 that was due upon receipt. Review on 09/09/24 at 2:47 P.M., of emails between the facility and the facility's medical equipment supplier, dated 08/19/24-08/21/24, revealed the account is currently at risk of credit hold due to lack of payment and the amount of past due invoices and a payment was required immediately to avoid service interruption. Interview on 09/09/24 at 2:05 P.M. with Medical Equipment Supplier Agent #6000, for the facility's medical equipment supplier, revealed the facility had contacted the medical equipment supplier on 09/09/24 to begin working on a payment plan. Review on 09/11/24 at 12:51 P.M. of a payment plan agreement, dated 09/11/24 and signed by both parties, revealed the facility agrees to pay the medical equipment supplier $5,000.00 on the 21st day of each month as well as the full among of the previous months invoice. If the facility fails to make any payment the medical equipment supplier can place the facility on an immediate credit hold. 3. Review of the facility's fire protection service company invoice dated 07/24/24 with a balance of $20,104. 87 that was due upon receipt. Interview on 09/11/24 at 12:40 P.M., with the facility's fire protection service company, Chief Financial Officer (CFO) #7000, revealed the facility has agreed to pay $5,000 on approximately 09/15/24 and will continue to make $5,000.00 payments on the 15th of each month until the balance is paid in full and services rendered from this provider going forward will be paid within the timeframe designated per contract. Review on 09/12/24 at 6:10 A.M. of a payment plan agreement, dated 09/11/24 and signed by both parties, revealed the facility agrees to pay $5,000.00 on the 15th of each month until the past due balance is paid and services rendered from this provider to the facility going forward will be paid within the timeframe designated per contract. Interview on 09/09/24 at 3:30 P.M., with the Administrator revealed the facility electric bill, medical equipment supplier bill, and fire protection provider bill were allowed to fall behind as the facility was undergoing repairs and updates and the facility needed to pause payments on those accounts to allow for the facility to have money for the needed repairs. This deficiency represents non-compliance investigated under Complaint Number OH00157379.