STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, staff interview, and facility policy, the facility failed to notify a resident representative of a change of condition. This affected one (Resident #41) of three residents reviewed for notification of change. The facility census was 69. Findings include: Review of the medical record revealed Resident #41 was admitted on [DATE]. Diagnoses included acute and chronic respiratory failure, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, lymphedema, chronic kidney disease stage three, acute respiratory failure with hypoxia, bilateral primary osteoarthritis of knee, fibromyalgia, essential primary hypertension, and hyperlipidemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of the nursing note dated 11/18/24 at 12:29 A.M. revealed Resident #41 complained of shortness of breath and her chest feeling heavy. The resident's oxygen saturation was in the 70's and 80's at two liters of oxygen and increased to five liters with improvement of oxygen saturation in the 80's. Resident #41 was non-compliant with the non-breather mask stating it was choking her. Resident #41 stated there was no relief from increasing oxygen and would like to be sent to the emergency room . The physician and Director of Nursing were notified. Emergency medical services were called to assist and Resident #41 left the faciity on [DATE] at 11:51 P.M. with emergency medical services. Report was called to the hospital and code status was faxed. Further review of the medical record revealed no documentation Resident #41's representative was notified of the residents change in condition and transfer to the hospital. Interview on 12/30/24 at 11:16 A.M. with the Administrator verified notification of change in condition and transfer to the hospital was not made to Resident #41's representative. Interview on 12/30/24 at 1:13 P.M. with Registered Nurse (RN) #202 verified providing care to Resident #41 on 11/17/24 and did not notify Resident #41's representative of the change in condition or transfer to the hospital. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025
NAME OF PROVIDER OR SUPPLIER: Spring Creek Nursing and Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Notification of Family/Responsible, dated November 2023, verified if there becomes a change in the status of a resident the responsible party and/or family member should be notified via preferred method in a timely manner of those changes and what treatment plan will be implemented. This deficiency represents non-compliance investigated under Complaint Number OH00160699.