

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 08/27/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and review of the facility policy, the facility failed to ensure the residents had a homelike environment. This affected three (#22, #23, and #24) of four residents reviewed for homelike environment. The facility census was 72.1. Review of the medical record for Resident #22 revealed a re-admission on [DATE]. Diagnoses included chronic obstructive pulmonary disease and seizures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had severe cognitive impairment. Observation and interview on 08/14/25 at 8:45 A.M. of Resident #22's bathroom revealed a sink with a built in soap dispenser holder without a soap container in the holder. There was not any soap or paper towels available. Interview on 08/14/25 at 8:45 A.M. with Resident #22 stated she ambulates with one assist to the restroom. Resident #22 stated to wash his hands, the Certified Nursing Aide (CNA) would have to get a washcloth and soap from outside of the room. Resident #22 stated to dry his hands he would have to use a towel if no paper towels were available. Interview on 08/14/25 at 8:51 A.M. with Housekeeper #159 revealed if a resident does not have hand soap in the bathroom, they would immediately replace it. Housekeeper #159 stated at times the delivery truck does not show up with products and they run short. Interview on 08/14/25 at 11:10 A.M. with Plant Operations Director (POD) #102 confirmed Resident #22 did not have hand soap or paper towels available. 2. Review of the medical record for Resident #23 revealed an admission on [DATE]. Diagnoses included fracture of left femur and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. Interview on 08/14/25 at 8:23 A.M. with Resident #23 revealed the soap dispenser in her room did not work. Resident #23 stated she spoke to Housekeeping Director (HD) #121 without result. Resident #23 stated she had to purchase her own hand soap due to the facility not providing it for her. Resident #23 stated she was unable to use the sink that was by the entrance door to her room due to being in a wheelchair and not being able to reach the soap dispenser. Observation on 08/14/25 at 8:30 A.M. of Resident #23's bathroom revealed a sink that had a built in soap dispenser. The soap dispenser was empty and difficult to push down. There were no paper towels available. Interview on 08/14/25 at 8:51 A.M. with Housekeeper #159 revealed if a resident does not have hand soap in the bathroom, they would immediately replace it. When asked why Resident #23 did not have any soap available, Housekeeper #159 stated that was the old dispensers and were unsure if they had soap to fit it. Housekeeper #159 stated at times the delivery truck does not show up with products and they run short. Interview on 08/14/25 at 11:10 A.M. with Plant Operations Director (POD) #102 confirmed Resident #23 did not have soap or paper towels available in the bathroom. 3. Review of the medical record for Resident #24 revealed an admission on [DATE]. Diagnoses included acute osteomyelitis and end stage renal disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact. Observation and interview on 08/14/25 at 8:40 A.M. revealed Resident #24's bedroom had a sink when you walk into the room. The sink had tape on it with a piece of paper that read out of order. In Resident #24's bathroom, there was a wash basin in the sink filled to the top with water that was leaking from the sink, overflowing onto the floor. There was no hand soap or paper towels available in the bathroom. Resident #24 stated he was unsure how long it had been since the sink when entering the room was out of order. Resident #24 said if he needed his hands washed, the Certified Nursing Assistant (CNA) would have to use a washcloth with bar soap. Resident #24 stated staff use a towel to dry his hands. Interview on 08/14/25 at 8:51 A.M. with Housekeeper #159 revealed if a resident does not have hand soap in the bathroom, they would immediately replace it. Housekeeper #159 stated at times the delivery truck does not show up with products and they run short. Interview on 08/14/25 at 10:43 A.M. with the HD #121 confirmed every resident bathroom should have soap and water. Interview on 08/14/25 at 11:10 A.M. with Plant Operations Director (POD) #102 confirmed Resident #24 did not have a working sink in the room, and was unsure how long it had been out of order. Review of the facility's undated policy titled Housekeeping Standards revealed housekeeping is to assist in delivering the highest quality care possible by being the primary care-givers of the environment. This is accomplished by providing and maintain a clean, safe and healthy environment including personal hygiene items. This deficiency represents non-compliance investigated under Complaint Number 2565440.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to develop a care plan based on Resident #23's medical needs. This affected one (#23) of one resident reviewed for care plans. The facility census was 72. Review of the medical record for Resident #23 revealed an admission on [DATE]. Diagnoses included type I diabetes mellitus (DM). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. Review of Resident #23's physician orders dated 06/05/25 revealed an order for insulin aspart injection solution 100 units (u) per milliliter (ml). Inject 100 units subcutaneously as needed for type I DM, administered through insulin pump. Review of the care plan for Resident #23 dated 06/25/25 revealed there was no care plan developed for Resident #23's diagnosis of type I DM, use of insulin for DM and management of Resident #23's insulin pump. Interview on 08/14/25 at 8:30 A.M. with Resident #23 revealed there have been times when she has low blood sugars and required staff to give her snacks to help bring her sugar up. Interview on 08/14/25 at 2:14 P.M. with Registered Nurse (RN) #620 revealed Resident #23 has stated that her sugar was low and RN #620 will give her snacks. RN #620 confirmed there was no documentation of times when Resident #23's sugar was low, nor were there orders to monitor. RN #620 verified there was no care plan in place pertaining to how to care for Resident #23's insulin pump or manage her type I DM. Interview on 08/14/25 at 2:28 P.M. with Director of Nursing (DON) confirmed Resident #23 did not have a care plan outlining her type I DM care. This was an incidental finding discovered during the course of the complaint investigation.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation, resident and staff interviews, and review of the facility policy, the facility failed to ensure the resident's call devices were functioning in their bathroom and/or bedrooms and failed to ensure the residents had accessibility and/or functionality of call devices in the shower rooms. This affected three (#22, #23, and #24) of five residents reviewed for call lights and had the potential to affect the residents who utilize the showers on first and third floor. The facility census was 74.1. Observation and interview on 08/14/25 at 8:45 A.M. revealed Resident #22's bathroom call light did not work. Resident #22 stated he would just wait for staff to come back after he was toileted. He could not recall if he used his call light or not. Interview on 08/14/25 at 11:10 A.M. with Plant Operation Director (POD) #102 confirmed Resident #22's bathroom call light did not work. 2. Observation and interview on 08/14/25 at 8:30 A.M. revealed Resident #23's bathroom call light was in the pulled position and the light was not functioning. Interview on 08/14/25 at 8:30 A.M. with Resident #23 revealed sometime in July she was in the bathroom and pulled the call light and it did not work. Resident #23 stated she sat on the toilet for over an hour. During that time, she said she yelled out for help and someone came and helped her. Interview on 08/14/25 at 11:10 A.M. with Plant Operation Director (POD) #102 confirmed the call light in Resident #23's bathroom did not work. POD #102 stated the bathroom call systems function on batteries, and if the batteries die there was no way to know. POD #102 stated sometimes the wiring in the call systems fry the wiring and do not allow the batteries to function for more than a day. 3. Observation on 08/14/25 at 8:40 A.M. in Resident #24's room revealed his bedside call light and bathroom call light were not working. Observation on 08/14/25 at 8:48 A.M. of the one west hall shower room revealed two call lights in the shower room did not function when pulled. Observation on 08/14/25 at 12:30 P.M. of the third-floor bathroom revealed there was no call light in the area of the shower. There was a call light on the opposite side of the wall next to the wash basin and one approximately ten feet from the shower that did not have a pull cord. Interview on 08/14/25 with Plant Operation Director (POD) #102 confirmed Resident #24's bedroom call light and bathroom call light did not work, the one west bathroom call lights. POD #102 confirmed the third floor bathroom did not have a call light readily available in the shower and furthermore the call lights that were in the bathroom did not work. Review of the policy titled Answering the Call Light dated March 2021 revealed periodically as needed staff should explain and demonstrate the use of the call light to residents. Staff should be sure the call light is plugged in and functioning at all times. Some residents may not be able to use their call light. Be sure to check on these residents frequently. Report all defective call lights to the nurse supervisor promptly. This deficiency represents non-compliance investigated under Complaint Number 2565440.</p>		