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	09/15/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, review of resident shower sheets and shower schedules, and facility policy review, the facility failed to ensure residents who were dependent on staff for bathing received showers on their scheduled days per their preference. This affected three (#17, #25, and #67) of four residents reviewed for showers. The facility census was 68. Findings include: 1. Review of the medical record for Resident #17 revealed an original admission date of 12/04/13 with re-admission to the facility on [DATE]. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease (COPD) and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident was assessed to require maximal assistance with showers and was dependent on staff to transfer into the shower. Review of the care plan dated 07/26/22 revealed Resident #17 had an activities of daily living (ADLs) self-care performance deficit related to fatigue, musculoskeletal impairment, activity intolerance, limited mobility, pain, and impaired balance. Interventions included Resident #17 was able to bath with ones staff member assist, and transfer with two staff member assist using the mechanical lift. Resident #17 was able to assist with hygiene. Review of the certified nurse aide (CNA) shower documentation in Resident #17's medical record revealed no documentation for the months of August and September 2025 for showers. Review of the skin monitoring shower review sheet completed by the CNAs for the months of August 2025 and September 2025 revealed there was not a sheet completed on Thursday, 09/11/25. Review of the shower schedule document for the One South hall revealed Resident #17 was to receive a shower on Mondays and Thursdays from 7:00 P.M. to 7:00 A.M. Interview on 09/15/25 at 8:56 A.M. with Resident #17 revealed he was scheduled to receive a shower twice a week the night shift and stated he does not always get his showers as scheduled. 2. Review of the medical record for Resident #25 revealed an admission date of 05/22/25. Diagnoses included fracture of the right lower leg, COPD, and bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #25 had intact cognition as evidence by a BIMS score of 15. Resident #25 was assessed to require moderate assistance with showering, and supervision or touching assistance with transfers. Resident #25 required moderate assistance with transferring in and out of the shower. Review of the care plan dated 05/23/25 revealed Resident #25 had an ADLs deficit related to a right lower extremity fracture. Interventions included providing a sponge bath when a full bath or shower cannot be tolerated. Resident #25 required assistance by staff with personal hygiene and oral care. Resident #25 required one staff member assist for transferring. Further review of the care plan revealed Resident #25 was at risk for falls related to impaired mobility. Interventions included staff meeting the residents' needs for physical assistance. Review of the Three South-Side One CNA report sheet revealed Resident #25 was scheduled for a night shift shower every Sunday and Wednesday. Review of the Three South shower sheet updated 07/22/25 revealed Resident #25 was to receive a shower from 7:00 A.M. to 7:00 P.M. on Sunday and Wednesday. Review of the CNA shower documentation in the medical record revealed Resident #25 did not receive a shower on Sunday, 09/14/25. Review of the skin monitoring CNA shower review for Resident #25 revealed no documentation on 09/14/25. Interview on 09/15/25 at 9:18 A.M. with CNA #342 revealed there were times when residents would have to wait to receive showers. CNA #342 stated staff complete shower documentation in the resident's electronic medical record (EMR) under the Tasks section, and they also fill out the skin monitoring shower review sheet. If residents refuse showers, the staff would document the refusal and notify the nurse. CNA #342 confirmed there was not a shower sheet for Resident #25 on 09/14/25 and there was no documentation in the medical record. Interview on 09/15/25 at 11:18 A.M. with Resident #25 revealed the resident was scheduled to receive showers twice a week and stated showers were not always completed as scheduled. Interview on 09/15/25 at 2:10 P.M. with CNA #301 revealed that on the shower sheet it was documented Resident #25 was a day shift shower; however, on the report sheet it was documented that the resident a third shift shower. CNA #301 stated she gave report to the night shift staff and told them Resident #25 did not receive a shower during the day on 09/14/25, and it needed complete on night shift. CNA #301 stated Resident #25 does not refuse showers unless the resident was in pain and then the CNAs will provide a bed bath. 3. Review of the medical Record for Resident #67 revealed an admission date of 06/05/25. Diagnoses included unspecified fracture of the left femur, polyneuropathy, and COPD. Review of the admission MDS assessment dated [DATE] revealed Resident #67 had intact