STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365586	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Creek Nursing Center	141 Spruce Lane West Union, OH 45693

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure residents received mechanically altered diets as ordered by the physician. This affected one resident (#69) out of the five residents reviewed for nutrition during the annual and complaint survey. The facility census was 70. Findings include:Record review for Resident #69 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included cerebral infarct, muscle weakness, and dysphagia (difficulty swallowing). Review of the admission Minimum Data Set (MDS) assessment, dated 04/19/26, revealed the resident had impaired cognition. The resident was assessed to receive a mechanically altered diet. Review of the care plan, last reviewed/revised on 06/23/26, revealed the resident had increased nutrition/hydration risk. Interventions included to provide diet as ordered. Review of the active physicians order, dated 04/15/26, revealed the resident was to receive a pureed texture diet with nectar thick liquids. Review of the facility recipe for pureed egg omelet baked, not dated, revealed refer to regular recipe instructions, then measure the desired number of servings into the food processor. Blend until smooth. Add milk if product needs thinning. Add commercial thickener if product needs thickening. Observation on 06/23/26 at 8:50 A.M. revealed Resident #69 was sitting up in her wheelchair in her room eating her breakfast meal. No staff were present in the room. The meal ticket on the residents tray indicated the resident was to receive a pureed baked omelet. The residents breakfast plate had scrambled eggs which were lumpy in texture present on it which the resident was consuming. Observation and interview with Registered Nurse (RN) #300 on 06/23/26 at 8:55 A.M. of Resident #69's breakfast tray confirmed there were scrambled eggs present on the residents plate and no pureed omelet despite the residents meal ticket indicating the resident was to receive a pureed omelet. RN #300 confirmed she would take the plate back to the kitchen and correct the food to meet the residents physician ordered diet. Review of the facility policy titled Puree Food Preparation Guidance, not dated, revealed the puree product is to be maintained between a pudding-like or mashed potato equivalent thickness. This deficiency represents non-compliance identified during the investigation of Complaint Number 2986097.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and review of facility policy, the facility failed to ensure resident rooms were maintained in a clean and sanitary manner. This affected two residents (#55 and #69) whose room was observed during the annual and complaint survey. The facility census was 70. Findings include:Observation on 06/22/26 at 8:15 A.M. revealed a strong urine odor was present in the room of Resident #55 and Resident #69 which could be smelled from the hallway. Observation on 06/22/26 at 12:03 P.M. revealed Resident #55 and Resident #69 were sitting in their room consuming their lunch meals. The urine odor continued to be present in the room. Housekeeper #401 entered the room to clean and mop. Observation on 06/22/26 at 4:15 P.M. revealed Resident #69 was lying in the bed. The sheets contained a rust-colored, circular stain on them located near the residents grab bar. Light brown stains were located on the sheets around where the residents feet were lying. Cobwebs and dust were present on the walls and ceiling between the residents sink and window, and debris was present underneath Resident #55 and Resident #69's beds and on the floor underneath the nightstand which was located under the residents television. The corner of the residents nightstand, which was located below the residents television, was broken and had been taped. The tape contained brown and pink stains and appeared to be old. The odor of urine remained present in the room. Observation on 06/23/26 at 9:45 A.M. revealed Resident #69's sheets continued to have a rust-colored, circular stain present near the residents grab bar with light brown stains located on the sheets near the foot of the residents bed. The cobwebs and dust remained on the ceiling and walls between the residents sink and window. Debris continued to be present under the beds of both Resident #55 and Resident #69 and under the nightstand located beneath the television. The odor of urine remained present in the room. Observation on 06/24/26 at 3:05 P.M. revealed Resident #69's sheets continued to have a rust-colored, circular stain present near the residents grab bar with light brown stains located on the sheets near the foot of the residents bed. The cobwebs and dust remained on the ceiling and walls between the residents sink and window. Debris continued to be present under the beds of both Resident #55 and Resident #69 and under the nightstand located beneath the television. The odor of urine remained present in the room. Interview with Certified Nursing Assistant (CNA) #710 and CNA #718 at the time of the observation confirmed there were cobwebs and dust present on the walls and ceiling between the residents sink and window, confirmed there was debris under the beds of both residents and the nightstand located under the television, and confirmed Resident #69's sheets had a rust-colored, circular stain located near the residents grab bar and also light brown stains near the foot of the residents bed. They confirmed residents bed sheets were to be changed on their shower days and Resident #69 was scheduled to receive a shower on day shift that same day. They confirmed there was a strong urine odor present in the room likely related to Resident #55 being incontinent of urine in large amounts which may saturate through her incontinence briefs into the mattress. Observation on 06/25/26 at 12:10 P.M. revealed Resident #69's sheets continued to have a rust-colored, circular stain present near the residents grab bar with light brown stains located on the sheets near the foot of the residents bed. The cobwebs and dust remained on the ceiling and walls between the residents sink and window. Debris continued to be present under the beds of both Resident #55 and Resident #69 and under the nightstand located beneath the television. The corner of the residents nightstand under the television continued to have a broken corner which had dirty tape holding the broken corner in place. The odor of urine remained present in the room. Interview with Licensed Practical Nurse (LPN) #603 at the time of the observation confirmed all observations. LPN #603 confirmed Resident #69's sheets needed to be changed immediately following the observation, confirmed the nightstand needed repaired or replaced, confirmed the room needed to be cleaned, and confirmed there was a urine odor present which may be related to a resident located in the room next to Resident #55 and Resident #69 who was incontinent (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and non-compliant with care. Review of the facility policy titled Occupied Standard Room Cleaning Procedure, last reviewed/revised 04/16/26, revealed proper cleaning and disinfecting of environmental surfaces is necessary to break the chain of infection. Cleaning referes to the removal of visible soil from surfaces through the physical action of scrubbing with detergents/surfactants and rinsing with water. Occupied resident rooms will be cleaned daily to maintain a sanitary environment. This deficiency represents non-compliance identified during the investigation of Complaint Number 2986097.