STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366185	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillspring Health Care & Rehab	325 East Central Avenue Springboro, OH 45066

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure staff allowed a resident to have her personal cell phone. This affected one (Resident #2) of three residents reviewed for personal property. The facility census was 127.Findings include:Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included chronic diastolic heart failure, chronic kidney disease, stage three, dementia, anxiety disorder, history of falling, and mild cognitive impairment.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 had moderately impaired cognition, and required set up assistance from staff with eating and personal hygiene. Review of the progress note for Resident #2 dated 05/09/26 written by Registered Nurse (RN) #10 revealed the resident's cell phone was placed in A hall medication cart to avoid it getting misplaced due to resident confusion.Interview on 06/16/26 at 7:56 A.M. with RN #10 revealed RN #10 placed Resident #2's personal cell phone in the medication cart, because she was so confused. RN #10 does not recall if she had informed any other staff.Interview on 06/17/26 at 7:24 A.M. with Nurse Aide in Training (NAT) #20 confirmed the nurses removed Resident #2's personal cell phone from Resident #2's room for multiple days. Interview on 06/17/26 at 8:08 A.M. with Director of Social Services (SSD) #30 revealed SSD #30 was notified of Resident #2's missing cell phone and it was in the nursing medication cart for six days away from the resident. SSD #30 stated it was reported to the Administrator on 05/15/26.Interview on 06/17/26 at 8:26 A.M. with the Administrator confirmed on 05/15/26, she was made aware of the Resident #2's cell phone being put it the medication cart.Review of the policy titled Resident Rights Respect and Dignity Retain and Use of Personal Possessions, dated 10/2022, revealed the facility should not limit a resident's ability to retain or have a personal items in their room. This deficiency represents non-compliance investigated under Complaint Number 3015077.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to ensure the resident's privacy was maintained during personal care. This affected one (Resident #43) of three residents reviewed for privacy. The facility census was 127.Findings include:Review of the medical record revealed Resident #43 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebrovascular disease, vascular dementia, anxiety disorder and major depressive disorder.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 was cognitively intact and dependent on staff for toileting. Interview and observation on 06/16/26 at 2:05 P.M. to 2:20 P.M. revealed Certified Nursing Assistants (CNA) #40 and CNA #50 provided peri care to Resident #43. Resident #43 was in a semi private room with a roommate, completing the peri care with no privacy curtains pulled on either side of Resident #43. There were no curtains drawn on the door (window from top of door to bottom of door) to the outside facing the street and parking lot and the window open to the outside street and parking lot with cars going by. Both CNA #40 and CNA #50 confirmed the privacy curtains should have been pulled and the window coverings for the door and window should have been closed. Interview on 06/17/26 at 8:43 A.M. with the Assistant Director of Nursing (ADON) #60 revealed CNAs should close privacy curtains and window coverings when providing personal care.Review of the facility's Resident Handbook with the Resident Rights dated 04/2026, revealed the resident right to privacy during medical examination or treatment and in the care of personal or bodily needs.This was an incidental finding discovered during the complaint investigation.

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	366185	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facilities Self-Reported Incidents (SRI), staff interview, and policy review, the facility failed to ensure all allegations of physical abuse were reported to the State Survey Agency. This affected one (#2) of one resident reviewed for abuse. Findings include: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included chronic diastolic heart failure, chronic kidney disease, stage three, dementia, anxiety disorder, history of falling, and mild cognitive impairment.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 had moderately impaired cognition, dependent on staff with bathing and required set up assistance from staff with eating and personal hygiene. Review of the progress notes dated 06/06/26 revealed Resident #2 exhibited behaviors. Resident #2 stated Certified Nursing Assistant (CNA) pushed her during care, resident appeared confused and provided inconsistent information when questioned further. There were no injuries, redness, bruising, or other signs of trauma were observed upon assessment. Interventions attempted, including nonpharmacological: reassurance, redirection, and resident's safety was maintained. Resident #2 calmed down. Review of the facilities SRIs from 06/06/26 to 06/16/26 revealed there were no allegations of physical abuse reported to the State Survey Agency involving Resident #2 being pushed by a CNA.Interview on 06/17/26 at 10:40 A.M. with the Administrator revealed the nurse who documented the progress note dated 06/06/26 regarding Resident #2 being pushed did not report this to anyone. The Administrator stated this should have been reported and confirmed the investigation started when they found this information out on 06/06/26. Review of the policy titled Abuse, Neglect, Misappropriation of Property, dated 09/2022 revealed ensure that all staff are aware that they need to report all incidents and allegations of abuse, neglect, mistreatment, exploitation and misappropriation of resident property.This was an incidental finding discovered during the complaint investigation.