STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47567 Based on observations, interviews, and review of facility policy, it was determined the facility failed to maintain a safe, clean, comfortable and homelike environment for twenty-six (26) sampled residents. The findings include: Review of the facility's policy titled, Routine Cleaning and Disinfection, not dated, revealed it is the facility's policy to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. The policy stated routine surface cleaning and disinfection will be conducted with detailed focus on visibly soiled surfaces and high touch areas to include but not limited to toilet flush handles, bed rails, tray tables, call buttons, IV poles, television remotes, and telephones. Review of the facility's policy titled, Resident Environmental Quality,not dated, revealed it was the facility's policy to ensure the facility was designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The policy stated preventative maintenance schedules for the maintenance of the building and equipment, should be followed to maintain a safe environment. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, not dated, revealed reusable resident care equipment will be cleaned and disinfected in accordance with current Centers for Disease Control and Prevention (CDC) recommendations in order to break the chain of infection. Review of the facility's document titled, Grievance/Concern Form, dated [DATE], revealed concerns regarding overall cleanliness of the facility and floors being stained with what appeared to be fecal matter. Further review of the document revealed the facility concluded the floors and walls were stained, but not by fecal matter and deep cleaning of the rooms was to be done by the housekeeping staff. Observations of the facilty on [DATE] at 9:00 AM, [DATE] at 1:50 PM, and [DATE] at 10:00 AM, revealed the bottom of Resident (R) 65's infusion pole was coated in a dried brown substance. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 - Some	Observations on [DATE] at 9:00 AM, [DATE] at 3:00 PM, [DATE] at 1:50 PM, [DATE] at 10:00 AM, and [DATE] at 8:00 AM, revealed the floors throughout the main corridors were heavily stained with large amounts of wax build up and grime. An additional observation of R65's room on [DATE] at 2:44 PM, revealed the floors appeared to have a yellowish film. Review of Resident 65's Facesheet revealed the facility admitted the resident on [DATE], with diagnoses that included cerebral palsy, dysphagia, and adult failure to thrive. Review of R65's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview of Mental Status (BIMS) had not been conducted as R65 was rarely or never understood. In an interview with a State Guardian on [DATE] at 9:59 AM, he stated he came to the facility to see his residents and the facility's overall appearance was dirty and unsanitary. He stated some of the walls had areas of chipped paint, feces or something brown was smeared on some of the walls and privacy curtain. The State Guardian stated the floors were dirty and appeared as if they had not been touched. He stated while he was there they did make some room changes for some of those residents (to deep clean), and he returned at a later date to see for himself if there were any changes. He stated some repairs had been completed, and the floor was cleaner. However, it still needed more than what they had done to improve the safety concerns that he was talking about. He stated that the staff members he encountered seemed apathetic and were not very concerned about taking care of the residents right away and that was a concern to him. He stated his goal was to get all of his guardianship residents moved to another facility where they would be better served and he was actively pursuing that at this time. In an interview with Licensed Practical Nurse (LPN) 4 on [DATE] at 2:43 PM, she stated night shift CNAs were assigned to clean medical equipment. LPN4 stated she did not have Resident 65, but she had taken care of him in the past. She stated when she did she would try to make sure the IV (intravenous) infusion pole was clean. In an interview with Licensed Practical Nurse (LPN)12 on [DATE] at 2:44 PM, she stated nightshift CNA staff was responsible for cleaning medical equipment such as wheelchairs and infusion stands. LPN12 stated if the CNA staff addressed it in report they could pass that task on to day shift to complete if needed. In an interview with Housekeeper (HK) 2 on [DATE] at 2:56 PM, he stated in the past, management was very lax and did not enforce rules and standards for the staff and some staff members would not perform their job duties. He stated resident rooms would not get cleaned and the management did not check the rooms. He stated they still have some things to improve on. He stated that the housekeepers deep clean at least once or twice a month. HK 2 stated that he was the facility's second floor tech and would rescrub floors as needed, as they were not getting cleaned like they should. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 - Some	In an interview with the facility's Floor Technician on [DATE] at 4:18 PM, he stated mostly he cleans the floors, but sometimes he does housekeeping. He stated when he worked as the floor technician he tried to do all of the floors daily. He stated that it had been awhile since the floors had been stripped and waxed. During the interview he stated they had been working on the 100 hall doing those floors first and had not done anything to this side of the building in a long time. The Floor Technician stated the floor wax in R65's room had expired, and that was the reason it had turned yellow in color. He stated if people came into the facility and saw the floors they would think that it was an ill ran facility. He stated he would get orders from the director on when to strip the floors and wax them, but the problem was when to do it as it was an all day job to move residents out of the room and into another room prior to refinishing the floors. In an interview with the Former Environmental Services Director (FESD) on [DATE] at 3:36 PM , He stated it was always a problem trying to keep up with maintaining the facility because administration did not want to spend more money to provide the proper services needed by hiring additional staff and order extra cleaning supplies. He stated he was told he was not doing his job although he barely had any resources to do the job. The FESD stated he had a meeting with the owner of the facility and talked to him a long time about what all he needed, but the owner disagreed with him. He stated he was a housekeeper before he became the director, and he always knew what the facility needed, but he simply could not keep up because he did not have enough housekeeping staff. In an interview with the Current Director of Environmental Services on [DATE] at 12:00 PM, she stated she had only been in this position for approximately two weeks and was still attempting to get things sorted out. She stated she tried to ensure that resident rooms were being cleaned by checking the housekeeping staff's work. She stated she was in the process of revising policies and making new documentation for staff to record when they were performing cleaning duties and what was being done. In an interview with the Director of Nursing (DON) on [DATE] at 3:38 PM, she stated nursing staff was responsible for cleaning the extended use medical equipment. She stated if a resident was discharged then Environmental Services would be responsible for cleaning it once the discharge has occurred. She stated it was her expectations that the facility was kept clean to create a homelike environment for the residents. She stated she would delegate monitoring the environment to her supervisors and make sure that they were monitoring to ensure that the rooms were being clean. In an interview with the Administrator on [DATE] at 4:16 PM, she stated she never knew about the IV pole, and she would discuss it with DON. She stated the CNAs should not mess with any medical equipment at all. The Administrator stated she would get with the DON and discuss it and determine who would be responsible for cleaning the medical equpment. She stated she did not think the CNAs should be doing it . If a nurse saw it was dirty they should take care of it regardless. The Administrator stated she had ordered the staff to stop polishing and putting wax down because she noticed they had placed wax on dirty floors. She stated her responsibility was to ensure compliance overall, including the safety of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37031 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 26 sampled residents (Resident (R)529). Immediate Jeopardy (IJ) was identified on 05/09/2025 and was determined to exist on 04/18/2025 in the area of S483.25(d) Accidents Hazards, F689. On 05/09/2025, the Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template and notified that the failure to ensure residents were provided supervision and protected from elopement is likely to cause serious injury, impairment, or death and constituted IJ at 42 CFR 483.25 F689. The IJ at F689 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.25, Quality of Care. The IJ was determined to exist on 04/18/2025, when the facility discovered R529 had eloped from the building. The facility provided an acceptable plan for the removal of the IJ on 05/10/2025. The plan alleged the IJ was removed, and the deficient practice was corrected on 05/10/2025. The plan provided by the facility alleged the following: On 04/18/2025 at approximately 2:58 PM, R529 was found outside the facility on the loading dock. She was assisted back into the facility by Certified Nurse Aide (CNA) 3. Immediately following the elopement event, the Unit Manager completed a head-to-toe skin assessment and pain evaluation of R529 with no injuries or pain noted. The wander guard to her left ankle was noted to be in place at that time. R529's Physician and family/responsible party were notified of the event. The Maintenance Director inspected the storage door and found the lock to be broken. He immediately repaired the door by placing a keypad lock on it. An Extended Survey and IJ Removal validation was conducted on 05/10/2025, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 05/10/2025. The SSA validated the immediacy of the IJ had been removed on 05/10/2025, as alleged. The findings include: Review of the facility's policy, Accidents and Supervision (Copyright 2024 The Compliance Store, LLC) revealed the resident environment was to remain as free of accident hazards as was possible. Per review, each resident was to receive adequate supervision and assistive devices to prevent accidents which included: identifying hazard(s) and risk(s); evaluating and analyzing hazard(s) and risk(s); implementing interventions to reduce hazard(s) and risk(s); monitoring for effectiveness and modifying interventions when necessary; and supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy, Elopements and Wandering Residents, undated, revealed the facility was to ensure that residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents. Per review, residents exhibiting wandering behavior or who were at risk of elopement were to also receive care in accordance with their person-centered plan of care which was to address the unique factors contributing to wandering or elopement risk. Further policy review revealed, Elopement occurred when a resident left the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Review of the facility's Emergency Preparedness Education page for Facility Elopement (Code Brown) revealed the Resident Elopement Information and Protocol, undated, noted wandering residents were at greater risk of injury if they walked away from the facility. Further review revealed Our Code [NAME] policy addressed that issue and outlined the protocol that allowed the facility to quickly find any missing resident. Review of the facility's Elopement Binder titled, Code [NAME] revealed the facility had assessed 16 residents to be at risk for elopement. The residents were listed in the binder. Review of the closed record Face Sheet for R529 revealed the facility admitted the resident on 04/03/2025, with diagnoses which included mild cognition and alcohol abuse. Review of R529's Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. Review of the facility's Elopement Risk assessment dated [DATE] for R529 revealed the resident scored a 3 which indicated on the Score Key a score of 0-5 was low risk for elopement. Review of the facility's Elopement Risk assessment dated [DATE] for R529 revealed the resident scored 13 which indicated on the Score Key a score of 12 or greater was high risk for elopement. Per review, elopement precautions put in place by the facility included: monitoring placement of wander guard every shift; and reporting to the nurse if unable to locate the resident. Continued review revealed an Elopement Risk Care Plan was initiated on 04/16/2025, with interventions to check exit door alarms daily; check wander alert bracelet daily; and to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Further review revealed the interventions also included to observe for exit seeking behaviors and patterns; and to redirect the resident from doors and exit as indicated. Review of R529's Elopement Risk assessment dated [DATE] revealed a score of 14 which the Score Key indicated if 12 or greater indicated the resident was a high risk for elopement. However, further review revealed no additional interventions were added to the Elopement Risk Care Plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Comprehensive Care Plan revealed the Elopement Risk Care Plan dated 04/16/2025, noted R529 was to be monitored daily for wander guard placement and the function of the wander guard. Per review, the Elopement Risk Care Plan Goal initiated on 04/16/2025, was the resident would not elope. Continued review of the care plan revealed the interventions included: every 15 minute security checks initiated 04/18/2025 (date of elopement) get the resident with a room in an area with high traffic for increased monitoring initiated 04/18/2025; and a wander guard was placed to the resident's left ankle initiated on 04/16/2025. Further review of the Comprehensive Care Plan dated 04/09/2025 for R529 revealed the facility assessed the resident to have behavioral problems related to walking around not clothed, picking at wounds, and taking dressings off her wounds. Per review, the interventions included: anticipating the resident's needs based on wandering triggers and patterns; assisting R529 in developing more appropriate methods of coping and interfacing, and to express her feelings appropriately. Continued review revealed additional interventions included: letting staff know when R529 was getting upset; diverting the resident's attention, and removing her from situations and taking her to another location if needed. Based on video footage of the elopment provided by the facility on 04/18/2025 at approximately 2:58 PM, R529 walked 71 yards from her room through two sets of double doors, into a staff meeting/break room, out a single storage room door and then through a door outside onto the loading dock. R529 was found on the dock, where she found a lift and was raised 81 inches from the pavement below Review of the facility's Word Document titled, Incident, dated 04/18/2025, revealed on that date at approximately 2:59 PM, the Maintenance Director observed R529 standing near an exit out of the station area as reported by a housekeeper. Per review, the resident was on the facility's premises, and was assisted back to Station 2, assessed for injuries with none noted, and the resident's wander guard was in place and functioning. Further review revealed every 15 minute checks were initiated for R529, and the resident was moved to a room in a higher traffic area, with a pathway by the nurse's station, dining, and therapy before going towards Station 3. Continued review revealed maintenance immediately determined the supply area exit door lock was broken (which led outside), and immediately repaired the door lock. Further review revealed upon completion of the investigation, it was determined there had been no failure with facility policies and processes. Additional review revealed the Incident Report had not been signed. Review of the video of the break room at 2:58 PM, revealed HK5 is sitting at a table with her head down looking at her phone and turned away from the door. R529 entered the room and walked straight to the storage room door. R529 opened the door and went through the door. HK5 never looked up from her phone. During interview with HK 5 on 05/08/2025 at 1:59 PM, she stated she worked the AM shift from 8:00 AM to 4:30 PM the day of R529's elopement. She stated she had been taking a break when the incident occurred, and had not looked up to see the resident come into the break room. HK 5 said she had to pick up briefs for a resident after her break, and never saw R529 up on the dock at all. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone (phone) interview on 05/08/2025 at 9:33 AM, HK4 stated it was his second or third day as a new employee working at the facility, and he was moving beds out of Station 3 to be checked by maintenance. He stated, near 3:00 PM, he went outside looking for the Maintenance Director, and when he opened the door he saw R529 out there on the dock. HK4 stated he said Hello to R529, and she started taking a couple of steps backwards. He stated R529 started talking and pointing at the maintenance man's truck, and he did not want to startle the resident or walk towards her, so he told her to hold on one second. HK 4 stated he ran straight to maintenance and told them he thought there was a resident out on the dock, and they all ran out to the dock. He stated the Maintenance Director called a Code Brown. HK 4 further stated the Maintenance Director went up behind R529 and grabbed hold of her sweat shirt and backed her away from the edge of the dock. In interview with the Maintenance Director on 05/07/2025 at 11:11 AM, he stated on 04/18/2025, my assistant and I were in my office, and a housekeeper came to my office and said there was a resident on the dock. He stated We immediately went and saw her (R529) about 12 foot in the air. The Maintenance Director stated he put out on the What's App (a social media, instant messaging application) that there was a resident outside on the dock. He stated he then went around to the back and up to R529 and grabbed hold of the sweat shirt she had on and held her until staff came out to the dock. The Maintenance Director stated there had been a misunderstanding regarding R529's elopement. He stated the Administrator had been told by someone that R529 had not exited the building; however, he took the Administrator out on the dock (during the state survey) on 05/09/2025 and showed her exactly where R529 had been. The Maintenance Director stated after the incident, he changed the door lock over to a combination lock so it could not be left open. He stated R529's wander guard had been working; however, it had not sounded because the service door she exited out of had no alarm on it for the wanderguard. The Maintenance Director stated, We had no work orders for that specific door, so he had no idea the lock was broken. He stated R529's exit out the service door was not discussed the next morning. In interview on 05/07/2025 at 11:50 AM, the Maintenance Assistant stated he had been in the shop with the Maintenance Director discussing work, when a housekeeper came into the office and said there was someone on the dock. He said We jumped up and went out, and saw R529, who had a wanderguard on her ankle. The Maintenance Assistant stated R529 appeared confused and said she needed to get to her truck and pointed to my truck He explained he told the resident that was his truck and she then said her truck was over here. He stated the Maintenance Director went around behind R529 up the steps and he (Maintenance Assistant) stayed below in case the resident fell . The Maintenance Assistant stated R529 had been right on the edge of the dock, up high, probably about 10 to 12 feet. He further stated the Maintenance Director grabbed her sweatshirt from behind and then lowered the hydraulic dock. He stated by that time a Certified Nurse Aide (CNA) came and took the resident back to her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 05/08/2025 at 10:26 AM, the MDS Nurse stated (on the day of R529's elopement) she saw a strange message on the Whats App, that said, General Store. Resident needs help. She stated she got up and walked back to the (break room) area where there were several other staff members. The MDS Nurse stated she was told a resident had gotten out the exit door, and at that time they were bringing R529 back in. She stated the door knob on the exit door was similar to a bedroom door where it was turned and pushed. The MDS Nurse stated she was told the exit door lock had not been working. She stated all she heard was that R529 had gotten out and was found on the dock, but she had not personally seen the resident outside. Per the MDS Nurse, she called the DON and told her R529 had gotten out through the break room exit door, and said she was told to do an immediate skin check of the resident. She stated she told a CNA to do one on one (1:1) with R529, and Registered Nurse (RN) 1 did a head count of all residents and all residents were accounted for. The MDS Nurse explained she walked back to the exit door, and observed the door had been repaired with a combination keypad. She further stated when she interviewed R529 for her MDS Assessment the resident had been confused at times. In interview on 05/07/2025 at 11:57 AM, the DON stated she had worked that day, but had gone home early, around 1:30 PM. She stated she received a call sometime after 3:00 PM from the MDS Nurse, who told her a resident had eloped; however, was okay. The DON stated the Unit Coordinator (UC) had been with R529, and she investigated and determined the resident had gone out the storage room door to the outside. Per the DON Housekeeper (HK) 4 had told her that R529 had been out on the loading dock. The DON stated We assessed R529, placed her on every 15 minute checks, and moved her further away from the doors leading into the unit. She stated with the resident being found out on the loading dock, she (DON) would consider that an elopement. During the interview, the DON stated in hindsight yes, that the incident should have reported. She stated she expected staff to keep residents safe, to make sure doors/locks were not broken, and complete the wander assessments. The DON further stated the facility currently had 16 residents who were wanderers. During interview on 05/07/2025 at 2:02 PM, CNA 3 stated she was the restorative aide (RA). She stated she had been at the business office and heard on the Whats app that a resident had been found out on the dock. The CNA stated that she ran back there, and saw the Maintenance Director and Maintenance Assistant standing on each side of R529 and assisting her towards the door. She further she took over from them, assisted R529 into a wheelchair and transported the resident back to her unit. In interview on 05/08/2025 at 1:52 PM, CNA 4 stated she had worked at the facility for three years and worked on Section 2 most of the time. She stated she saw R529 before 3:00 PM, when the resident's call light went off and she went to her room. The CNA stated five to 10 minutes later, CNA 3 rolled R529 onto the unit in a wheelchair, and told her the resident had gotten out onto the dock. She stated she remembered R529 had been more confused that day than usual. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. Building B. Wing	05/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Post-Acute Rehabilitation Center	1401 South 16th Street Murray, KY 42071

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 05/07/2025 at 2:15 PM, the Station 2 UC stated she had been packing up stuff to leave for the day, when she was alerted a resident from Station 2 had gotten outside. She stated she called the DON and Assistant Director of Nursing (ADON), and assessed R529 to make sure she was not hurt. The Station 2 UC stated she sat with R529 and talked to her for 10 to 15 minutes, trying to find out how the elopement happened. She stated R529 was placed on every 15 minute checks. The UC stated she went with maintenance personnel to see exactly what happened. The Station 2 UC stated she took witness statements, and moved R529 from Station 2 to Station 1 where the resident could be more closely monitored. She stated R529 had tried to exit seek before and we did an Elopement Screen and found she was a high elopement risk. The Station 2 UC stated R529 was on a wander guard and had been found at the doors before. She explained R529's cognition had changed drastically and she had gotten more and more confused, and that was why We did several (risk) assessments. The Station 2 UC stated R529 had been on every 15 checks all weekend. During an additional interview on 05/08/2025 at 2:19 PM, the Maintenance Director stated no one had ever mentioned to him that the (break room) exit door lock was broken. He stated the facility used the TELS system (a building management platform) for staff to communicate any maintenance concerns; however, he had not received any communications about the door lock being broken. During interview with the Administrator on 05/07/2025 at 10:15 AM, regarding the elopement of R529, she stated she had not been at the facility when the incident occurred. The Administrator stated she had been told R529 had not gotten out of the facility, and after discussion with the Director of Nursing (DON) it was decided it had not been an elopement. She further stated however, she had not been aware the resident got out of the door and onto the dock. During additional interview with the Administrator on 05/07/2025 at 4:43 PM, she stated she knew the door the resident exited the building was used as housekeeping storage. However, she had not been in that room. She stated she held an ad hoc meeting over the phone with the Maintenance Director and the DON, but had not talked with the Medical Director. In interview on 05/08/2025 at 4:24 PM, the Director of Social Services (DSS) stated, regarding BIMS scores for R529, the resident did have a cognitive impairment when she was first admitted to the facility. The DSS said R529 had shown exit seeking behavior also; however, she had not seen the resident do that. The DSS reported updating the Code [NAME] book and emailing it to the DON, ADON, Therapy, Maintenance, Housekeeping, UC's, Administration, Dietary and Activities staff. The DSS further stated all the Code [NAME] binders were on the units and were labeled Code Brown. In a phone interview on 05/08/2025 at 4:46 PM, R529's daughter stated she was aware her mother had gotten out of the building. She stated she got her information from her Mom's sister who called her after she heard about anything going on with her Mom. R529's daughter said since she lived in Georgia, her Aunt took care of her Mom, and her Aunt lived with her Mom in her Mom's house. She stated her Mom would not speak with the SSA Surveyor on the phone.