

| | | | |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility policy review, the facility failed to ensure residents had a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility related to residents with eating difficulties for four (4) of 26 sampled residents (Resident (R) 32, 106, R122, , R111) and one (1) unsampled resident (R2).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Promoting/Maintaining Resident Dignity, undated, revealed the facility would protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintained or enhanced the resident's quality of life by recognizing each resident's individuality. Further review of the policy revealed all staff members were involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</p> <p>1. Review of Resident R32's Facesheet revealed the facility admitted the resident on 05/20/2019 with diagnoses which included, polyarthritis, muscle wasting and atrophy, and dementia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment for R32 dated 03/20/2025, revealed a Brief Interview for Mental Status (BIMS) score of one (1) out of fifteen (15) which indicated severe cognitive impairment.</p> <p>2. Review of R106's facesheet revealed the facility admitted the resident on 06/28/2024 with diagnoses which included muscle wasting and atrophy, need for assistance with personal care, and cognitive communication deficit.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS' score of 9 which indicated the resident had a moderate cognition impairment.</p> <p>3. Review of R111's facesheet revealed the facility admitted the resident on 01/12/2024 with diagnoses which included: altered mental status, cognitive communication deficit, and need for assistance with personal care.</p> <p>Review of R111's Quarterly MDS dated [DATE] revealed a BIMS' score of 13 which indicated the resident's cognition was intact.</p> <p>(continued on next page)</p> |

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: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
|--|--|
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>4. Review of R122's facesheet revealed the facility admitted the resident on 03/06/2025 with diagnoses which included chronic pulmonary edema, inappropriate diet and eating habits, adult failure to thrive, and alzheimer's disease with late onset.</p> <p>Review of R122's admission MDS dated [DATE] revealed a BIMS' score of 3 which indicated severe cognitive impairment.</p> <p>During an observation on 05/06/2025 at 12:22 PM in the Station 4 dining room, revealed R32, R106, R111, and R122 were draped with bath towels instead of clothing protectors or napkins. There was a large black plastic container against the wall with a Towels sign above the container.</p> <p>Observation during the dinner meal on 05/06/2025 at 5:15 PM revealed the residents were draped with bath towels again.</p> <p>During an interview with R41 on 05/10/2025 at 2:48 PM, she stated she would like extra napkins but she gets two towels that she lays across her to protect her clothing. R41 stated that she would use a towel because the clothing protectors that the facility looked so raggedy they would not protect anybody's clothing.</p> <p>During an interview on 05/10/2025 at 2:55 PM, R54 stated she always wanted to use something to cover her clothing when eating.</p> <p>During an interview with Certified Nurse Aide (CNA) 9 on 05/09/2025 at 4:32 PM she stated, residents have the right to refuse to use a towel. She stated, We use towels in place of bibs and (they) are used based on BIMS and capabilities.</p> <p>During an interview with Licensed Practical Nurse (LPN) 13 on 05/10/2025 at 2:52 PM, she stated, use of towels for clothing protectors was based on the resident" ability. She stated, We do not make anybody wear it.</p> <p>During an interview with CNA11, on 05/10/2025 at 4:10 PM she stated, she sometimes offers the residents clothing protectors. When asked to describe it, she stated it looked just like a towel. Don't offer anything else. She stated, there were some residents who prefer to have a napkin in their lap and they do have access to that, stating that it was the paper one that comes on their tray.</p> <p>During an interview with CNA12 on 05/10/2025 at 4:15 PM, she stated she assists with trays. The CNA stated that she offered towels to the residents because she doesn't know where the clothing protectors are, adding she believed they may be on the 400 Hall. CNA12 stated, They have napkins that their utensils are wrapped in. She stated that if she was helping in the dining room she would just go ahead and put a napkin in there lap without asking out of habit.</p> <p>During an interview with the Director of Nursing on 05/09/2025 at 4:38 PM she stated she thought it was fine to use a bath towel as a clothing protector for residents. She stated she was not sure if the facility had clothing protectors and if there were some, there was not enough for all the residents.</p> <p>During an interview with the Administrator on 05/10/2025 at 4:35 PM, she stated, We should ask the residents if they want clothing protectors. Towels are not appropriate at all.</p> |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>The findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Observations of the facility 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>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.</p> <p>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.</p> <p>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 equipment. 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.</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).</p> <p>Immediate Jeopardy (IJ) was identified on 05/09/2025 and was determined to exist on 04/18/2025 in the area of &sect;483.25(d) Accidents Hazards, F689.</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>The findings include:</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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.</p> <p>Review of the facility's Elopement Binder titled, Code Brown revealed the facility had assessed 16 residents to be at risk for elopement. The residents were listed in the binder.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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.</p> <p>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</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 Brown 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 Brown binders were on the units and were labeled Code Brown.</p> <p>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.</p> | | |

| | | | |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
|---|---|
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure food was distributed and served in accordance with professional standards for food service safety for 4 of 26 sampled residents (Resident (R)111, R106, R32, and R122).</p> <p>The findings include:</p> <p>Review of the facility's policy, Serving a Meal, undated, revealed it was the facility's policy to serve meals that met the nutritional needs of residents. Continued review revealed the Policy Explanation and Compliance Guidelines included: Avoid handling actual unwrapped food items with bare hands.</p> <p>Observation of the dinner meal service on 05/06/2025 at 5:15 PM, revealed Licensed Practical Nurse (LPN)14 touched four residents' (R111, R106, R32, and R122's) buns with her bare hands while cutting the residents' sandwiches in half. Further observation revealed LPN14 also touched the residents' straws with her bare hands when placing the straws in the residents' drinks.</p> <p>During interview with LPN14 on 05/09/2025 at 12:15 PM, she stated she honestly should have had gloves on. She stated she thought of the residents as family and had not thought of wearing gloves.</p> <p>In interview on 05/09/2025 at 4:38 PM, the Director of Nursing (DON), stated she expected staff not to touch food and straws with their bare hands. She stated she expected staff to follow the facility's policy.</p> <p>During interview with the Administrator on 05/10/2025 at 4:35 PM, regarding staff using their bare hands with food handling and when opening straws, she stated she expected staff to wear clean gloves when handling food. She stated staff should remove the paper from straws properly, without touching the straw with their bare hands.</p> |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on interview, record review, review of the facility's Director of Nursing (DON) and Administrator's Job Descriptions, and policy review, the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident related to the facility's Administrator and/or DON failed to notify the state regulatory office on the elopement on 04/18/2025 of R529.</p> <p>The findings include:</p> <p>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.</p> <p>Review of the facility's policy titled, Governing Body, undated, revealed the facility was to have a governing body or designated persons functioning as a governing body that were legally responsible for establishing and implementing policies regarding the management and operations of the facility. Per review, the governing body was to appoint an Administrator who was licensed by the state where required and responsible for management of the facility. Continued review revealed the governing body was to have a process in place by which the Administrator knew what specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) were to be reported or not reported to the state agency/agencies.</p> <p>Review of the facility's policy, Elopements and Wandering Residents, undated, under Procedure for Locating Missing Resident, revealed appropriate reporting requirements to the State Survey Agency (SSA) should be conducted.</p> <p>Review of the facility's Administrator Job Description dated 09/10/2020, revealed the Administrator was to plan, coordinate and manage all services and employees of the facility. Per review, the Administrator was responsible for the overall direction, coordination, and evaluation of all care and services provided to the Elders (residents) of the facility. Continued review revealed the facility's Administrator oversaw and maintained quality care, service and culture that was consistent with and exceeded organizational, state and federal regulatory standards as directed by the facility's team. Further review revealed the facility's Administrator was to have the ability to communicate effectively and advocate for Elder centered/directed care to team members, families, and physicians.</p> <p>Additional review of the Administrator Job Description revealed the Administrator was to understand all regulations including, federal, state, and Life Safety Code (LSC) regulations. Review further revealed the Administrator was to ensure all regulations were covered by a facility policy and/or procedure and conversely, to ensure all existing policies and procedures were compliant with said regulations.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the facility's DON Job Description, undated, revealed the DON was to manage and direct the day to day functions of the Nursing Department in accordance with established policies, procedures, and practices that complied with federal, state, and local regulations. Per review, the DON was to demonstrate knowledge of the residents' physical, social, emotional, and psychological needs based on the health care required. Continued review revealed the DON was to ensure adequate staffing patterns, and that staff were qualified and trained. Further review revealed the DON's essential functions included: ensuring required documentation was complete and was in compliance with regulations and standards. Additionally, the DON's professional requirements included maintaining regulatory requirements, including all state, federal and local regulations.</p> <p>In interview on 05/07/2025 at 11:57 AM, the DON stated she was not in the facility when R529's elopement took place. She stated she had worked that day, but went home early around 1:30 PM. The DON stated she received a call sometime after 3:00 PM, from the Minimum Data Set (MDS) Nurse, who told her a resident had eloped. She stated she investigated the incident and determined the resident had gone out the storage room door to the outside. The DON stated she would by definition consider that an elopement. The DON stated she expected staff to keep the residents safe and ensure doors/locks were not broken, and perform wander assessments. When asked by the State Survey Agency (SSA) Surveyor if she should have notified the state of R529's elopement, she stated in hindsight, yes. The DON further stated We will now report that but have not yet.</p> <p>In interview on 05/07/2025 at 10:15 AM, the Administrator stated, regarding the elopement of R529, she had not been there when the elopement happened. She stated she did not report it to the state because she did not think it was an elopement since she was told the resident did not get out of the facility. The Administrator stated she had discussed it with her DON and they decided it was not an elopement. She stated she was unaware the resident got out of the door and onto the dock. The Administrator stated R529 did not get off of the facility's property; however, after the regulation was reviewed with her, she stated it was an elopement and should have been reported to the state agency.</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on interview, record review, and facility policy review, it was determined the facility failed to review and update the facility's assessment which had the potential to affect 131 residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Facility Assessment, not dated, revealed the facility would conduct and document a facility-wide assessment to determine what resources were necessary to care for their residents competently during both day-to-day operations and emergencies. Further review revealed the Administrator was responsible for ensuring the completion of the facility's assessment and that it would be reviewed and updated as necessary and at least annually.</p> <p>Review of the Facility Assessment, dated 06//26/2023, revealed a review date of 07/11/2023 and it would be reviewed every third Tuesday of every month. The assessment identified it had the capacity to meet the needs of 226 residents. Further review revealed the census at that time averaged 115 residents.</p> <p>During an interview with the Director of Nursing (DON) on 05/10/2025 at 3:38 PM, she stated she had no responsibility related to the facility's assessment and that was the responsibility of the Administrator.</p> <p>Review of a statement from the Administrator, dated 05/06/2025, revealed she began working at the facility on 03/31/2025 and noticed the facility's assessment had not been updated.</p> <p>During an interview with the Administrator on 05/10/2025 at 4:15 PM, she stated one of the first things she looked at when she assumed her position was the facility's assessment. She stated she noticed it had not been completed since 2023. She stated she was currently working on updating the facility's assessment but was waiting on feedback from the residents and/or their representatives. The Administrator stated she was responsible for ensuring the assessment was reviewed and updated. She stated it takes time to complete and she had not had time to get it into place yet.</p> | | |

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>2. Continued review of the facility's policy titled, Infection Prevention and Control Program, undated, revealed environmental cleaning and disinfection was to be performed according to the facility's policy. Per review, all staff had responsibilities related to the cleanliness of the facility.</p> <p>Review of the facility's policy titled, Routine Cleaning and Disinfection, undated, revealed it was the facility's policy to ensure provision of routine cleaning and disinfection of intravenous (IV) infusion poles in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.</p> <p>Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, undated, revealed reusable resident care equipment was to be cleaned and disinfected in accordance with current Centers for Disease Control and Prevention (CDC) recommendations in order to break the chain of infection.</p> <p>Observations on 05/06/2025 at 9:00 AM; 05/08/2025 at 1:50 PM; and 05/09/2025 at 10:00 AM, revealed the bottom of R65's infusion pole was coated in a dried brown substance.</p> <p>In interview on 05/09/2025 at 2:44 PM, LPN 12 stated the night shift Certified Nurse Aide (CNA) staff were responsible for cleaning medical equipment, such as wheelchairs and infusion poles.</p> <p>In interview on 05/09/2025 at 3:38 PM, the DON stated nursing staff was responsible for cleaning the extended use medical equipment, such as infusion poles. She stated if a resident was discharged from the facility then Environmental Services was responsible for cleaning it once the discharge occurred.</p> <p>In interview on 05/10/2025 at 4:16 PM, the Administrator stated she was not aware that the IV pole needed cleaning, and would discuss that further with the DON.</p> <p>3. Review of the facility's policy titled, Transmission-Based (Isolation) Precautions, undated, revealed the facility would take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Per review of the policy, healthcare personnel caring for residents on contact precautions were to wear a gown and gloves for all interactions that might involve contact with the resident. Further review revealed healthcare personnel were to don (put on) personal protective equipment (PPE) upon entering the resident's room.</p> <p>Review of the admission Record for R229, revealed the facility admitted the resident on 04/28/2025, with diagnoses to include: unspecified open wound of abdominal wall, colostomy, and non-pressure chronic ulcer of left calf limited to breakdown of skin.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment with a ARD of 05/01/2025, revealed the facility assessed R229 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact.</p> <p>Review of the physician's order dated 04/30/2025 at 9:51 PM, revealed an order for the resident to have isolation contact precautions related to a parasite. Staff were to wear all PPE when entering R229's room.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Observation on 05/07/2025 at 4:58 PM, revealed CNA 1 entered R229's room with a lunch tray; however, failed to don the required PPE prior to entering the room.</p> <p>During interview with CNA 1 on 05/06/2025 at 5:05 PM, she stated she worked through an agency. CNA 1 stated she should have donned a gown, gloves and mask when she took R229's lunch tray into his room. She stated she had been in a hurry due to only having 15 minutes to pass lunch trays to the other residents. The CNA stated she should have followed the guidelines to prevent herself from getting an infection. She further stated she had received education related to Transmission Based Precautions prior to starting work at the facility.</p> <p>During interview with the DON on 05/09/2025 at 3:38 PM, she stated she was the facility's acting Infection Prevention (IP) Nurse. She stated staff should wear PPE when providing direct care if a resident was on contact precautions. When the State Survey Agency (SSA) Surveyor asked the DON what the requirements were for residents on contact precautions, she said, staff should wear PPE prior to entering a resident's room who was on contact precautions. The DON stated staff could end up with whatever organism the resident had on their clothing and possibly spread it to other residents and staff. She stated she expected her staff to wear PPE as required. The DON stated education was provided to staff during monthly meetings and online trainings were also assigned for staff to review. She explained agency staff were educated by the agency they were hired through and were not permitted to pick up shifts until the education had been completed. The DON further stated however, she did not verify the staff education had been completed.</p> <p>During interview with the Administrator on 05/10/2025 at 4:15 PM, she stated she expected staff to follow the rules on whatever precautions the resident was placed on. She stated a sign was placed on the outside of the resident's door for the precautions staff were to follow. The Administrator stated she expected staff to follow the facility's policy. She stated she did not know if there would be a negative outcome if staff did not follow the precautions; however, they could spread an illness to others in the facility.</p> <p>Based on observation, interview, record review and facility policy review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 6 of 26 sampled residents, (Resident (R)32, R65, R106, R111, R122, and R229)</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Infection Prevention and Control Program, undated, revealed the facility was to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Per review, all staff should assume all residents were potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Continued review revealed hand hygiene should be performed in accordance with the facility's established hand hygiene procedures. Further review of the policy revealed all staff were to use personal protective equipment (PPE) according to established facility policy governing the use of PPE.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/10/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Post-Acute Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the facility's policy, Serving a Meal, undated, revealed the Policy Explanation and Compliance Guidelines included: Avoid handling actual unwrapped food items with bare hands.</p> <p>Observation on 05/06/2025 at 5:15 PM, of the dinner meal service, revealed Licensed Practical Nurse (LPN) 14 touched R122, R111, R32, and R106's sandwich buns with her bare hands while cutting their sandwiches in half. Continued observation revealed LPN 14 also touched the residents' straws with her bare hands when placing the straws in the residents' drinks.</p> <p>During interview on 05/09/2025 at 12:15 PM, LPN 14 stated she should have worn gloves when cutting the sandwiches and removing the resident's straw papers as she could pass infections to the residents.</p> <p>In interview on 05/10/2025 at 2:40 PM, the Director of Nursing (DON) stated she expected staff to avoid touching residents' food with their bare hands. She stated straw papers needed to be removed without touching the straw.</p> <p>In interview on 05/10/2025 at 4:35 PM, the Administrator stated she expected staff to wear clean gloves when handling residents' food, and remove the paper from straws without contamination.</p> | | |