

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/14/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRING CREEK HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1401 SOUTH 16TH STREET</b> <b>MURRAY, KY 42071</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/14/13, as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 10TH STREET MURRAY, KY 42071		
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F 000	INITIAL COMMENTS  A standard recertification survey was conducted 09/17/13 through 09/19/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E."	F 000	This plan of correction is submitted as the facility's credible allegation of compliance.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review and record review, it was determined the facility failed to ensure one resident (#10,) in the select sample of 24 residents, received the appropriate treatment and services to prevent infection, related to the failure to change the Gastric feeding pump tubing, connected to the feeding container and the failure to date and time the feeding container and the water used for flushing the feeding.  Findings include  A review of the undated Manufacturers recommendations for the maintenance of the Gastric Feeding System revealed due to the risk of bacterial contamination and overall system accuracy, feeding sets must be replaced every 24 hours and was intended for single use only.  A review of the facility's policy for Gastrostomy Management, dated March 2009, revealed closed systems, containing pre-filled formula containers	F 281	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  1. The corrective action accomplished for resident #10. a. Resident #10's feeding tubing that leads from the feeding pump to the feeding container was changed, dated and initialed on 9-19-2013. The feeding container and the water flush bag was labeled, dated, timed and initialed on 09-19-2013.  2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility on the days of the survey and had a gastric feeding system could have been affected by the same deficient practice.  3. Measures and systemic changes to ensure that the deficient practice will not recur:		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Sandra J Dick*

TITLE

*Administrator*

(X6) DATE

*10-8-13*

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

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F 281	<p>Continued From page 1</p> <p>with pump tubing, were to be changed when the bag was empty or at least every 48 hours. If the spike set needs to be changed, the container should also be changed. Open systems are changed every 24 hours. The container was to be labeled, with the date, time, name of the formula and the nurses initials.</p> <p>Observations 09/17-19/13, all three days of the survey, revealed the feeding tubing was flagged and dated "09/16/13," and the feeding container and the water flush bag was not labeled or dated until the last day of the survey on 09/19/13.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, and LPN #3, on 09/19/13 at 9:55 AM, revealed the whole feeding system was scheduled to have been changed, every 24 hours, by the nurse who worked the midnight shift, and the container and the water flush should have been dated, timed and initialed. The tubing that lead from the feeding pump to the feeding container had not been changed and was dated 09/16/13.</p> <p>An interview with the Director of Nurses, (DON), on 09/19/13 at 11:20 AM, revealed she was aware of the tubing and the unmarked containers and stated the tubing should have been changed everyday and the containers should have been marked.</p>	F 281	<p>a. The facility's policy and procedure for gastrostomy management has been reviewed and revised to meet the manufacturer's recommendations.</p> <p>b. The facility has in-serviced licensed staff on revised policy and procedure.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Unit Coordinator of each station will perform weekly audits to ensure adherence to policy.</p> <p>b. Results of audits will be submitted to the Director of Nursing weekly.</p> <p>c. The Unit Coordinator will report results of findings and corrective actions at the quarterly Quality Assurance Committee Meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with F281 deficiency effective 10/14/2013</p>	10/14/2013	
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>	F 371	<p>F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>1. The corrective action accomplished for those</p>		

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F 371	<p>Continued From page 2</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was served under sanitary conditions.</p> <p>Findings include:</p> <p>Review of the Food Service Policy Manual, revised 03/17/09, revealed handwashing was critical to the prevention of cross contamination and possible spread of illness.</p> <p>Observation, on 09/18/13 at 11:30 AM, revealed Cook #1 donned gloves, and prepared two resident trays on the tray line. She left the tray line and picked through the containers of lettuce and tomato wearing the soiled gloves. She put lettuce and tomato on a plate. She placed a hamburger bun on the counter top in front of the tray line, and then added the hamburger and cheese. She put the hamburger on the plate with the lettuce and tomato, then placed it on the food tray cart. Cook #1 returned to the tray line without changing her gloves or washing her hands. She continued to make resident trays wearing the soiled gloves. She left the tray line again, to make another hamburger. She picked through the tomato and lettuce, with the soiled gloves. She also obtained "tater tots" with her gloved hand, placing them on the plate with the hamburger.</p>	F 371	<p>accomplished for those residents found to have been affected by the deficient practice:</p> <ol style="list-style-type: none"> <li>a. No residents were found to have been affected by the deficient practice.</li> <li>b. Immediate education was given to cook #1 after notification was given to the Dietary Manager of deficient practice.</li> </ol> <p>2. Identification of other residents having the potential to be affected by the same deficient practice:</p> <ol style="list-style-type: none"> <li>a. It was determined that all residents residing in the facility on the days of the survey could have been affected by the same deficient practice.</li> </ol> <p>3. Measures and systemic changes to ensure that the deficient practice will not recur:</p> <ol style="list-style-type: none"> <li>a. The food service policy specific to safety and sanitation was reviewed and revised to be specific.</li> <li>b. Cook #1 was counseled.</li> </ol> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <ol style="list-style-type: none"> <li>a. The Dietary Manager will perform weekly visual audits to ensure adherence to food service policy.</li> </ol>		

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F 371	Continued From page 3 She returned to the tray line without removing the soiled gloves or washing her hands.  Interview with the Dietary Manager, on 09/18/13 at 2:00 PM, revealed Cook #1 should have donned clean gloves prior to obtaining food with her hands. She expected staff to wash their hands and change gloves before returning to the tray line.  Interview with the Administrator, on 09/19/13 at 10:00 AM, revealed she expected staff to follow the policy related to handwashing in the kitchen.	F 371	b. Immediate corrections will be made if indicated. c. The Dietary Manager will report any negative findings and corrective actions at the quarterly Quality Assurance Committee Meetings. d. Action plans will be developed if indicated. 5. The facility declares compliance with F371 deficiency effective 10/14/2013	10/14/2013	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F431 483.60(b)(d)(e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No residents were found to have been affected by the deficient practice. 2. Identification of other residents having the potential to be affected by the same deficient practice: b. It was determined that all residents residing in the facility on the days of the survey could have been affected by the same deficient practice. 3. Measures and systemic		

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F 431	<p>Continued From page 4</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure drugs and biologicals used in the facility were not expired.</p> <p>Findings include:</p> <p>Review of the Emergency Cart policy/procedure, revised 02/2004, revealed the licensed nurse checking the emergency cart would sign the checklist which would denote that the cart had been checked, cleaned, and out-dated supplies removed and replaced.</p> <p>Observation, on 09/18/13 at 2:30 PM, revealed two (2) intravenous (IV) bags containing 1000 milliliters (ml) of Lactated Ringers, with an expiration date of July 2013, available for use in the emergency cart on Station 2.</p> <p>Review of the Emergency Cart Check List, dated September 2013, revealed the supplies in the cart had been checked once daily from 09/01/13 through 09/17/13.</p>	F 431	<p>changes to ensure that the deficient practice will not recur:</p> <ol style="list-style-type: none"> <li>a. The two (2) intravenous (IV) bags of fluid were disposed of.</li> <li>b. The facility's emergency cart policy and procedure was reviewed and revised.</li> <li>c. The facility has in-serviced licensed staff on new policy and procedure.</li> </ol> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <ol style="list-style-type: none"> <li>a. The Assistant Director of Nursing will perform weekly audits to ensure adherence to policy.</li> <li>b. Results of audits will be submitted to the Director of Nursing weekly.</li> <li>c. The Assistant Director of Nursing will report results of findings and corrective actions at the quarterly Quality Assurance Committee Meetings.</li> <li>d. Action plans will be developed if indicated.</li> </ol> <p>5. The facility declares compliance with F431 deficiency effective 10/14/2013</p>	10/14/2013	

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F 431	Continued From page 5 Interview with Unit Manager #1, on 09/18/13 at 2:50 PM, revealed she expected the licensed nurse on night shift to check the emergency cart for expired supplies.  Interview with the Director of Nursing (DON), on 09/19/13 at 9:55 AM, revealed she expected the licensed nurse on night shift to fill out the emergency cart check list once a shift, verifying supplies were available and not expired.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No residents were found to have been affected by the deficient practice. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility on the days of the survey could have been affected by the same deficient practice. 3. Measures and systemic changes to ensure that the deficient practice will not recur: a. Infection control education was provided to licensed practical nurse LPN #1		

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F 441	<p>Continued From page 6</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which hand washing was indicated, including medication pass and meal service.</p> <p>Findings include:</p> <p>Review of the Medication Administration policy/procedure, revised 09/12, revealed to ensure hands were washed or hand sanitizer utilized between residents.</p> <p>Observation, on 09/19/13 at 7:25 AM, revealed Licensed Practical Nurse (LPN) #1 administered medications to a resident. She did not wash her hands or use hand sanitizer before the administration of medication to another resident at 7:30 AM.</p> <p>Interview with LPN #1, on 09/19/13 at 9:50 AM, revealed she should wash her hands after each resident while administering medications.</p>	F 441	<p>b. Infection control education was provided to cosmetologist.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Unit Coordinator will perform weekly audits to ensure adherence to infection control policy during medication pass.</p> <p>b. The Assistant Director of Nursing will perform weekly audits to ensure adherence to infection control policy during meal service.</p> <p>c. Results of audits will be submitted to the Director of Nursing weekly.</p> <p>d. The Director of Nursing will report results of findings and corrective actions at the quarterly Quality Assurance Committee Meetings.</p> <p>e. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with F441 deficiency effective 10/14/2013</p>	10/14/2013	

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F 441	Continued From page 7 Interview with the Director of Nursing (DON), on 09/19/13 at 9:55 AM, revealed she expected staff to wash their hands or use hand sanitizer between each resident while passing medication. A lunch meal observation on 09/17/13 and a breakfast meal observation on 09/19/13 revealed the facility Cosmetologist serving trays to residents without washing or sanitizing her hands in between passing each resident's tray. An interview with the Cosmetologist on 09/19/13 at 8:00 AM, revealed she was not aware of the need to wash her hands between each tray pass. A review of an in-service sheet dated 08/28/13, revealed the Cosmetologist signed the sheet indicating she had been in-serviced on appropriate hand washing during meal pass. An interview with Unit Manager #1 on 09/19/13 at 9 15 AM, revealed the Cosmetologist was involved in in-servicing periodically as well as computer training for infection control. She revealed she expected the Cosmetologist to sanitize her hands between each tray pass. An interview with the Director of Nursing on 09/19/13 at 10:25 AM, revealed the Cosmetologist was only to serve trays and set them up for the residents. She stated she expected her to use hand sanitizer and wash her hands between tray pass.	F 441			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced	F 463	F463 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/ BATH  1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. The bathrooms are for public use only. No residents were found to have been affected by the deficient practice.		

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F 463	<p>Continued From page 8</p> <p>by: Based on observation and interview, it was determined the facility failed to ensure each bathroom available for resident use was equipped to receive resident calls through a communication system.</p> <p>The findings include:</p> <p>There was no policy related to a call system in common area bathrooms.</p> <p>Observation, on 09/18/13 at 2:30 PM and 09/19/13 at 10:15 AM, revealed one bathroom across from the nurse's station and one located beside the nurse's station, on Station (1). There was a bathroom on Station (2), across from the therapy department. On Station (3), there was one women's bathroom and one men's bathroom. All five bathrooms were available for resident use, with no communication system in place.</p> <p>Interview with Unit Manager #2, on 09/19/13 at 9:20 AM, revealed residents usually use their own bathroom; however, there have been occasions when they use the common area bathrooms.</p> <p>Interview with the Director of Nursing (DON), on 09/19/13 at 9:55 AM, revealed the common area bathrooms were accessible for resident use. She witnessed a resident use one of the bathrooms on 09/18/13, while the resident's son waited outside the door for him/her.</p> <p>Interview with the Administrator, on 09/19/13 at 10:00 AM, revealed residents were not supposed to use the guest bathrooms. She verified there were five (5) bathrooms located in the facility with no communication system in place.</p>	F 463	<p>2. Identification of other residents having the potential to be affected by the same deficient practice:</p> <p>a. It was determined that all residents residing in the facility on the days of the survey could have been affected by the same deficient practice.</p> <p>3. Measures and systemic changes to ensure that the deficient practice will not recur:</p> <p>a. The public restrooms are now locked.</p> <p>b. The public restrooms are not for resident use and have signage to address this.</p> <p>c. Keys are located at each nurse's station.</p> <p>d. New policy was created for public restrooms for stations 1, 2, and 3.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Facility Assistant will perform weekly audits to ensure adherence to policy.</p> <p>b. Results of audits will be submitted to the Director of Nursing weekly.</p> <p>c. The facility Assistant will report results of findings and corrective actions at the quarterly Quality</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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  09/19/2013
NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			Assurance Committee Meetings. d. Action plans will be developed if indicated. 5. The facility declares compliance with F463 deficiency effective 10/14/2013	10/14/2013	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/14/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRING CREEK HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1401 SOUTH 16TH STREET</b> <b>MURRAY, KY 42071</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/14/13 as alleged.	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/18/2013
NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>****Amended Sod K-29 deleted****</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1964, 71, 83 and new building in 2006.</p> <p>SURVEY UNDER: 2000 Existing and 2000 New.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1964 upgraded in 2012, with 86 smoke detectors and 1 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system in the old part and a dry system installed in 1967 and 2006.</p> <p>GENERATOR: Two (2) Type II generators installed in 2006 and 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/17/13 and 09/18/13. Spring Creek Healthcare was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-three (153) on the day of the</p>	K 000	This plan of correction is submitted as the facility's credible allegation of compliance.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samdra J Dick TITLE: Administrator (X5) DATE: 11-6-13

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 11/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195005	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  09/18/2013
NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 1 survey.	K 000			
K 038 SS=F	<p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-three (153) on the day of the survey. The facility failed to ensure twelve (12) egress doors had the proper signage for delayed egress doors.</p> <p>The findings include: Observation, on 09/18/13 between 9:00 AM and</p>	K 038	<p><b>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <ol style="list-style-type: none"> <li>1. The corrective action accomplished for those residents found to have been affected by the deficient practice:             <ol style="list-style-type: none"> <li>a. No residents were found to have been affected by the deficient practice.</li> </ol> </li> <li>2. Identification of other residents having the potential to be affected by the same deficient practice:             <ol style="list-style-type: none"> <li>a. It was determined that all residents residing in the facility on the days of the survey could have been affected by the same deficient practice.</li> </ol> </li> <li>3. Measures and systemic changes to ensure that the deficient practice will not recur:             <ol style="list-style-type: none"> <li>a. The facility signs that were not equipped with signage for the delayed egress doors with no contrasting background on the signs</li> </ol> </li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	<p>Continued From page 2</p> <p>1:00 PM with the Maintenance Mechanic 2 and Facility Assistant, revealed twelve (12) doors in the facility were equipped with signage for the delayed egress doors with no contrasting background on the signs.</p> <p>Interview, on 09/18/13 between 9:00 AM and 1:00 PM with the Maintenance Mechanic 2 and Facility Assistant, revealed they were unaware the signs must have a contrasting background.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected</p>	K 038	<p>were removed.</p> <p>b. More signs were ordered to replace the ones removed.</p> <p>c. The signs were all installed on facility doors with the contrasting background.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Facility Assistant will perform weekly visual audits to ensure adherence to signage on egress doors with contrasting background.</p> <p>b. Immediate corrections will be made if indicated.</p> <p>c. The Facility Assistant will report any negative findings and corrective actions at the quarterly Quality Assurance Committee Meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with F371 deficiency effective 10/14/2013</p>	10/14/2013

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PRINTED: 11/06/2013  
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NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
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K 038	<p>Continued From page 3</p> <p>throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual</p>	K 038			

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NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	Continued From page 4 means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038			
K 068 SS-D	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, fourteen (14) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-three (153) on the day of the survey. The facility failed to ensure the station 1 fuel fired hot water heater was taking air directly from the outside.  The findings include:	K 068	K 068 NFPA 101 LIFE SAFETY CODE STANDARD  1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No residents were found to have been affected by the deficient practice. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility on the days of the survey could have been affected by the same deficient practice. 3. Measures and systemic changes to ensure that the		

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PRINTED: 11/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 068	<p>Continued From page 5</p> <p>Observation, on 09/18/13 at 9:15 AM with the Maintenance Mechanic 2 and Facility Assistant, revealed the fresh air vent for the fuel-fired hot water heater was installed but only went to the attic of the facility.</p> <p>Interview, on 09/18/13 at 9:15 AM with the Maintenance Mechanic 2 and Facility Assistant, revealed they were unaware the piping stopped at the attic. There was other ductwork that looked like it was connected to the piping that did go to the outside of the facility.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.</p>	K 068	<p>deficient practice will not recur:</p> <ol style="list-style-type: none"> <li>a. The facility now has ventilation to outside of the facility in station one mechanical room.</li> <li>4. The facility plans to monitor its performance to ensure that solutions are sustained by:               <ol style="list-style-type: none"> <li>a. The Maintenance Supervisor will perform weekly audits to ensure proper ventilation.</li> <li>b. Results of audits will be submitted to the Facility Assistant.</li> <li>c. The Maintenance Supervisor will report results of findings and corrective actions at the quarterly Quality Assurance Committee Meetings.</li> <li>d. Action plans will be developed if indicated.</li> </ol> </li> <li>5. The facility declares compliance with F431 deficiency effective 10/14/2013</li> </ol>	10/14/2013	