STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	R 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK POST-ACUTE AND REHABILITATION CENTER	**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
{F 000}	INITIAL COMMENTS An Onsite Revisit conducted on 03/10/2021, determined the facility was in a compliance on 01/26/2021, as alleged in the acceptable PoC.	{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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 12/21/2020 and concluded on 12/23/2020. The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and had not implemented the Centers' for Medicare & Medicaid Services (CMS) and the Centers' for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census was 86.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	Brown bags with PPE were removed from the floor outside of resident #4's room and was disposed on 12/21/2020. Brown bags with PPE were removed from the floor outside of resident #6's room and was disposed on 12/21/2020. Rounds were made by DON and ADON on 12/21/2020 and no other brown bags found that required disposing. PPE storage stations were restocked on 12/21/2020 in hallway 400. Rounds were made on 12/21/2020 by the DON, ADON, Infection Preventionist, and Unit Coordinators to restock any needed PPE in both stations 1 and 4. Licensed Practical Nurse (LPN) #1 had removed gown upon leaving the resident's room. She doffed properly and passed two (2) resident's rooms in the process of walking to the appropriate disposal container. She did not place the gown in a disposable bag upon leaving the resident's room on her way to the disposal container in the hallway. There were no residents or staff in the hallway and no residents or staff were affected as Licensed Practical Nurse (LPN) #1 walked to the disposal container. The Infection Preventionist immediately in-serviced the Licensed Practical Nurse (LPN) #1 on 12/21/2020 on the appropriate disposal of PPE.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vicki Bradley-Steege Vicki Bradley-Steege	Vice President of Long Term Care	01/22/21

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 1 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880	Continued From page 1 All residents have the potential to be affected. #1 Root Cause Analysis was completed that identified that a policy and procedure needed to be implemented for restocking PPE. A policy and audit tool was created on 1/15/2021 and an in-service was initiated on 1/18/2021. The new policy and audit tool were discussed in QAPI on 1/18/2021. Root Cause Analysis was completed on 1/18/2021 and brought to and approved by Ad hoc QAPI members on 1/22/2021. #2 & #3 Root Cause Analysis was completed that identified that, although guidelines were in place for breathable bags for PPE, a policy and procedure needed to be implemented for usage of brown bags as storage for PPE. A policy and audit tool was created on 1/15/2021 and an in-service was initiated on 1/18/2021. Root Cause Analysis was completed on 1/18/2021 and brought to and approved by Ad hoc QAPI members on 1/22/2021. #4 Root Cause analysis was completed regarding doffing new PPE in-service clarification. The in-service was reviewed on 12/21/2020 and updated to reflect appropriate policy and procedure for doffing new PPE. An in-service had been re-initiated on 12/21/2020 and completed on 1/20/2021. The Root Cause Analysis brought to the Ad hoc QAPI members on 1/22/2021. (Continued on next page)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's policy review, it was determined the facility failed to implement and maintain an effective infection control program. Observations revealed a brown paper bag, that contained dirty PPE (Personal Protection Equipment), was left on the floor outside Resident #4's room. Additional observations revealed one brown paper bag, that contained clean PPE, was left on the floor outside Resident #6's room, and not stored in the storage area next to nurse's station per facility policy. Observation revealed staff exited Resident #5's isolation room folding and rolling a dirty gown, and then walked two (2) doors down to dispose it in a bin. The staff failed to place the gown in a plastic bag prior to walking down the hall, per facility policy. These failures created the potential of cross contamination. The findings include: Review of the facility's policy titled, "Isolation Categories", dated June 2007 revealed to protect patients and staff the guidelines of the Centers for Disease Control and Protection (CDC) have been adopted. The guidelines revealed transmission of infectious agents within a healthcare setting required three (3) elements: 1) a source of infectious agents; 2) a susceptible host with a portal of entry receptive to the agent; and, 3) a mode of transmission for the agent. Further review of the guidelines revealed that infectious agents transmitted during healthcare were primarily from human sources but could come	F 880	Cont. From page 2 Staff education provided on CDC COVID-19 prevention messages for frontline LTC staff "PPE lessons," new process on restocking PPE, new process for usage of brown bags for storage of PPE, and doffing of PPE, with all in-services completed by appropriate staff by 1/25/2021. Any staff who may be out due to time off or medical leave will be in-serviced upon their return to work. Education may be completed by the Director of Nursing, Assistant Director of Nursing, Staff Educator, Supervisors, and the Infection Control nurse via in-person or security cameras throughout the facility. Any immediate corrections will be addressed at the time of the incident and noted on the audit. Education is to be completed by 1/25/2021. The facility will perform audits on doffing PPE, the appropriate usage and storage of brown bags, and restocking PPE. These audits will be performed for fourteen (14) days across all shifts. Continued audits will be performed twice (2) a week for three (3) weeks, then weekly each shift for two (2) months. Audits will be completed by 5/25/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 3 from inanimate objects as well. When implementing standard precautions, assume every person is potentially infected with a transmittable organism, remove gown, and perform hand hygiene before leaving the patient's (resident's) environment. Review of the facility's policy titled, "Strategies for Optimizing the Supply of Isolation Gowns", last revised 10/09/2020, revealed the re-use of isolation gowns and the risk to the Health Care Professional (HCP) and patient safety must be carefully considered before implementing a gown reuse strategy. Reusable gowns should not be reused before laundering, due to the potential risk of transmission of organisms that likely outweigh any potential benefits. Gown reuse has the potential to facilitate transmission of organisms. Any gown visibly soiled during patient care should be disposed of or, if reusable, laundered. Review of the facility's policy, titled, "Strategies for Optimizing the Supply of Facemasks", last revised 11/23/2020, revealed facemasks used to protect staff's nose and mouth from exposure to splashes, sprays, splatter, and respiratory secretions (e.g., for patients on Droplet Precautions) should be removed and discarded after each patient encounter. When facemask used for source control while in the healthcare facility, to prevent spread of respiratory secretions when talking, sneezing, or coughing; the facemasks may be used until soiled, damaged, or hard to breathe through, then discarded immediately. Further review of the policy revealed when facemasks used for extended usage as in the practice of HCP wearing the same facemask (e.g., for patients on Droplet Precautions) during encounters with several different patients, without	F 880	Continued from page 3 Audits may be performed by the Director of Nursing, Assistant Director of Nursing, Staff Educator, Supervisors, and the Infection Control nurse via in-person or via security cameras throughout the facility. Any immediate corrections will be addressed at the time of the incident and noted on the audit. Result of all audits (doffing PPE, brown bags, restocking PPE) will be brought to the QAPI (Quality Assurance Performance Improvement) committee for review, to address any corrections needed, and to address any policy and procedure concerns.	01/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 4	F 880		

removing the facemask between encounters, the facemask should be discarded whenever the facemask is removed, and always at the end of each workday. The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.

Review of the facility's "Infection Control Survey Plan of Correction", dated 12/08/2020, revealed after you have provided care to a resident who is COVID positive you must remove/doff your gown and place in the "red" barrel prior to leaving the room. If the barrel is placed outside the door; remove the gown in the room and place in the barrel outside of the room. Further review of the PoC (Plan of Correction), revealed you should remove your dirty mask and face shield and place in a "dirty" paper bag labeled with your name. Then you should don (put on) a clean mask and face shield. Never go into the care areas with a "dirty" gown. Blue bags should be used for all soiled linen regardless of isolation or soiled with blood.

Review of a facility provided email titled "Gowns, Face-masks, and Shields, dated 12/20/2020, revealed when staff exit a COVID Isolation room; staff should remove their gown and place in an appropriate disposal bag. If disposable, staff should leave the gown in the red barrel in the room; and if a cloth gown, the gown should be placed in a blue bag upon removal. Staff should have a clean mask/face shield and a 'dirty" mask and face shield with paper bags labeled as such.

1. Observation of Hallway 400, on 12/21/2020 at approximately 11:28 AM, during tour of the facility, revealed Resident #3's room had a placard that read "Advanced Droplets: with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 5	F 880		

person wearing (PPE) personal protective equipment consisting of goggle or disposable full face shield, NIOSH (National Institute for Occupational Safety and Health)-approved N95 filtering face piece respirator or higher, gown, one pair of clean nonsterile gloves, no shoe or boot covers". Further observation revealed a bin located on the opposite side of the hall, two (2) rooms down utilized for Resident #3's and Resident #4's room, was empty of any available clean gowns for use in care of the isolated residents.

2. Observation of Resident #4's room, on 12/21/2020 at approximately 11:28 AM, revealed a brown paper bag in front of the door by the over the bed table (outside the room) and labeled "Dirty PPE" and had Hospitality Aide (HA) #1's name on the bag.

Interview on 12/21/2020 at approximately 12:08 PM, with Hospitality Aide (HA) #1, revealed she had left the brown bag at the door of a positive COVID room. HA #1 stated she had been at the facility on 12/20/2020 to see Resident #4 and had left at approximately 4:00 PM, not realizing that she had taken the wrong brown paper bag with PPE with her to dispose.

Further observation on 12/21/2020, at approximately 11:35 AM, revealed Licensed Practical Nurse (LPN) #1 removed a gown, mask, and shield from the brown paper bag that was in Resident #4's room.

Interview on 12/21/2020 at 11:30 AM-11:40 AM, with Licensed Practical Nurse (LPN) #1, revealed Resident #4 was COVID positive and under advanced droplet isolation precautions. LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 6	F 880		

stated that the bin in front of the room did not have any available clean gowns. She stated the person that removed the last gown should restock the bin and everyone should be monitoring the bins to ensure clean gowns were available. Additionally, LPN #1 stated the brown paper bag labeled "Dirty PPE" with HA #1's name on the bag had dirty PPE in the bag, and should not have been in front of the door. LPN #1 stated the outcome of the dirty PPE being left in the hallway was a potential to spread COVID.

3. Observation of Hallway 100, on 12/21/2020 at approximately 12:30 PM, revealed a brown paper bag stuffed between an overhead table and a storage bin on the floor outside Resident #6's room. Observation revealed LPN #3 checked the bag and it contained a gown, gloves, and three (3) masks and had LPN #4's name on the bag and was marked clean.

Interview on 12/21/2020 at 12:38 PM, with LPN #4, revealed the brown paper bag outside Resident #6's room was hers. LPN #4 stated she did not put the bag on the floor in the hallway, and she did not know anything about the bag being there because she did not have any residents on that hallway.

Interview on 12/21/2020 at 12:33 PM, with LPN #3, revealed gowns and masks should be placed in a brown paper bag when staff came out of the room and dirty or clean should be written on the bag and then it should be stored at the nurse's station. LPN #3 stated the risk of not doing this would be risk of exposure, but she did not know who monitored this.

4. Observation on 12/21/2020 at approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 7	F 880		

1:28 PM, during tour of Hall 100, revealed LPN #2 came out of an isolation room with isolation a gown in hand, folding it inward and rolling it up. She then proceeded down the hallway, taking the gown two (2) doors down and disposed of the gown in a large trash bin.

Interview on 12/21/2020 at 1:50 PM, with LPN #2, revealed she had taken the gown off in the hallway and placed it in the large barrel on the hallway. She stated she did not place the gown in a bag before leaving the room.

Interviews on 12/21/2020 at 12:35 PM, and 12/23/2020 at 9:30 AM, with Unit Manager #1, revealed the bags should not have been placed on the floor outside the rooms. UM #1 stated staff were supposed to have brown bags for each room, a clean bag and a dirty bag. The UM stated the outcome of bags left on the floor outside the room could contribute to cross contamination. UM #1 further revealed there were wanderers in the facility and they could get the bags that were left outside the rooms. UM #1 stated the nurse or the staff member was responsible for throwing away the dirty PPE, but it was other administrative staff's and her job to monitor the dirty and clean brown bags outside to ensure there was no cross contamination. UM #1 stated dirty gowns used in the room should be taken off in the room and placed in the blue barrel outside the room.

Interview on 12/23/2020 at 11:47 AM, with UM #2/Assistant Director of Nursing (ADON), revealed brown paper bags were stored in the storage rooms next to the nurse's station and if staff went into an isolation room they could get their bags and take them with them. The ADON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 8	F 880		

stated staff should take off their clean mask, shield, and put it in a brown bag that was labeled clean; and a dirty bag for their dirty PPE. UM #2/ADON stated once staff had completed resident care, they were to take off their gown, and place it in a clear bag or blue bag and tie it up. Staff then should take off their mask and shield and place them in the dirty brown paper bag. Continued interview revealed staff then should place the bag with the gown, in the receptacle, and take the paper bags into the storage room until needed again. UM #2/ADON revealed the nurse that failed to remove the gown prior to coming out of the room and not bagging the gown could cause cross contamination. UM #2/ADON stated to ensure staff removed and disposed of gowns properly they were conducting inservices and monitored as they walked down hallways. ADON/UM #2 stated the dirty PPE brown paper bag left in hallway since 4:00 PM the prior day could result in cross contamination. Further interview revealed the ADON/UM did not know who monitored the brown bags to ensure they were stored and disposed of properly. She stated it was a joint effort, and if she saw it, she would get rid of it. UM#2/ADON stated the clean brown bag left on the floor on the hall could also cause cross contamination.

Interview with the Infection Control Nurse (IFCN), on 12/23/2020 at 12:06 PM, revealed they started the brown paper bag usage because of the CDC recommendation for a bag for dirty and a bag for clean face shields and masks. The IFCN stated if staff were going into a COVID room they should place a dirty mask and shield on and when they come out they were to sanitize their hands, remove the shield and mask, and then place them in a brown (label the bag dirty) paperbag,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 9	F 880		

then put on the clean mask and shield. Further interview revealed the clean brown bag would have clean written on it. She revealed staff then would place the dirty brown paper bag in a room behind the nurse's station on the 100 Hall, and on the 400 Hall, they placed them in an equipment room. Continued interview revealed staff would be wearing the clean at that time and the empty clean bag should be placed in the room. She stated there was potential for contamination to whoever came into contact with the contents of the bag. She stated there were residents who wandered in the facility. The IFCN stated that she was not sure of a designated person for monitoring, but any administrative staff making rounds should be monitoring to ensure procedures were followed. She further stated they do competencies on doffing PPE, but no daily or weekly monitoring. She stated the outcome of the gowns not being disposed of properly was the potential to spread the infection to anyone that it came in contact.

Interview on 12/23/2020 at 12:38 PM, with the Director of Nursing (DON), revealed she expected the nurse to bag the dirty gown before leaving the room and dispose of it and by not doing this, it could result in cross contamination. The DON stated the dirty brown bag with the dirty PPE was supposed to be stored across from the nurse's station on the 400 Hall, until the end of the day, then it would be thrown away; as it was only worn in the isolation rooms. The DON further revealed there were residents who wandered on the 400 Hall and anyone coming in contact with items in the bag could be contaminated. She stated staff should monitor for these types of things when going up and down the hall. The DON also revealed the cleanpaper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	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
F 880	Continued From page 10 bag with clean PPE in it had the potential for cross contamination when left on the hall.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185005	A. BUILDING _____ B. WING _____	12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK HEALTH CARE	**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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/21/2020 and concluded on 12/23/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 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.