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

PRINTED: 09/03/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	185005 B. WING		09	09/02/2020			
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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE	
F 000	A COVID-19 Focused was initiated on 09/01 09/02/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	d Infection Control Survey /2020 and concluded on ity was found to be in FR 483.80 infection control implemented the Centers for Services (CMS) and Control and Prevention practices to prepare for	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.

Facility ID: 100756

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
185005		B. WING _		0	09/02/2020		
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	
E 000	Initial Comments A COVID-19 Focused Survey was initiated of concluded on 09/02/2	d Emergency Preparedness	E 0	DEFICIENCY)	PROPRIATE	DATE	

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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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 (X4.) ID PREFIX TAG (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 09/01/2020 and concluded on 09/02/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				NATE SURVEY OMPLETED		
SPRING CREEK HEALTH CARE 1401 SOUTH 16TH STREET MURRAY, KY 42071 (X4) ID PREFIX TAG N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 09/01/2020 and concluded on 09/02/2020. The facility was found to be in	100756		B. WING	B. WING		09/02/2020			
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 09/01/2020 and concluded on 09/02/2020. The facility was found to be in	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET								
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was initiated 09/01/2020 and concluded on 09/02/2020. The facility was found to be in	N 000	Initial Comments		N 000					
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