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

PRINTED: 11/06/2020 FORM APPROVED OMB NO. 0938-0391

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			11/05/2020	
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 PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 11/04 11/05/2020. The facili compliance with 42 C regulations and has it Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 4/2020 and concluded on ity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for		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: 11/06/2020 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 _		11	11/05/2020	
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	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Initial Comments		E 0	00			
	Survey was initiated of concluded on 11/05/2	d Emergency Preparedness on 11/04/2020 and 020. The facility was found vith 42 CFR 483.73 related					
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

(X6) DATE TITLE

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.

PRINTED: 11/06/2020 FORM APPROVED

Office of Inspector General

NAME OF PROVIDER OR SUPPLIER  SPRING CREEK HEALTH CARE  PREMIT THE STREET MURRAY, KY 42071  PREMIX (KY 42071)  N 000 Initial Commons of the C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE 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 11/04/2020 and concluded on 11/05/2020. The facility was found to be in	100756		B. WING	B. WING					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (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 11/04/2020 and concluded on 11/05/2020. The facility was found to be in		NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1401 SOUTH 16TH STREET							
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 11/04/2020 and concluded on 11/05/2020. The facility was found to be in			MURRAY	, KY 42071					
A COVID-19 Focused Infection Control Survey was initiated 11/04/2020 and concluded on 11/05/2020. The facility was found to be in	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI	JLD BE	COMPLETE		
was initiated 11/04/2020 and concluded on 11/05/2020. The facility was found to be in	N 000	Initial Comments		N 000					
		A COVID-19 Focused was initiated 11/04/20 11/05/2020. The facil	20 and concluded on ity was found to be in						

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

TITLE (X6) DATE