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

PRINTED: 11/18/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE S		
		185133	B. WING _			11/13/2020	
	ROVIDER OR SUPPLIER  ATER POINTE			STREET ADDRESS, CITY, STATE, ZIP 100 WEST RAMSEY DAWSON SPRINGS, KY 42408		11/13/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 000	was initiated on 11/12 11/13/2020. There wa identified with 42 CFF regulations and the fa Centers for Medicare and Centers for Disea (CDC) recommended COVID-19. Total cens	d Infection Control Survey 2/2020 and concluded on as no deficient practice R 483.80 infection control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention		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: 100436

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION  NG		(X3) DATE SUF COMPLET	
		185133	B. WING _		_	11/13/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 100 WEST RAMSEY DAWSON SPRINGS, KY		11/13/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTED CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 Focuser Survey was initiated of concluded on 11/13/2	d Emergency Preparedness					
LABORATORY	DIRECTOR'S OR PROVIDER/6	SUPPLIER REPRESENTATIVE'S SIGNATUR	PF	TITLE			(X6) DATE

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  100 WEST RAMSEY  DAWSON SPRINGS, KY 42408  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE)	MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NT OF DEFICIENCIES N OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  100 WEST RAMSEY DAWSON SPRINGS, KY 42408   (X4) ID PREFIX TAG  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 11/12/2020 and concluded on 11/13/2020. There was no deficient practice				
TRADEWATER POINTE  100 WEST RAMSEY DAWSON SPRINGS, KY 42408  (X4) ID PREFIX TAG  N 000 Initial Comments  A COVID-19 Focused Infection Control Survey was initiated 11/12/2020 and concluded on 11/13/2020. There was no deficient practice  100 WEST RAMSEY DAWSON SPRINGS, KY 42408  ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  N 000  N 000  A COVID-19 Focused Infection Control Survey was initiated 11/12/2020 and concluded on 11/13/2020. There was no deficient practice	NG 11/13/2020	100436		
TRADEWATER POINTE  DAWSON SPRINGS, KY 42408   (X4) ID			PROVIDER OR SUPPLIER	NAME OF P
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 11/12/2020 and concluded on 11/13/2020. There was no deficient practice			WATER POINTE	TRADEWA
A COVID-19 Focused Infection Control Survey was initiated 11/12/2020 and concluded on 11/13/2020. There was no deficient practice	REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	/ MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
was initiated 11/12/2020 and concluded on 11/13/2020. There was no deficient practice	00		00 Initial Comments	N 000
		20 and concluded on as no deficient practice	A COVID-19 Focused was initiated 11/12/20 11/13/2020. There w	

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

TITLE (X6) DATE