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

PRINTED: 05/22/2020 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	
		185407	B. WING	B. WING		04/02/2020	
	ROVIDER OR SUPPLIER MBERLAND REGIONAL	HOSPITAL SCU	•	STREET ADDRESS, CITY, STATE, ZIP CO 305 LANGDON STREET SOMERSET, KY 42503	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 000	conducted on 04/02/2 to be in compliance v Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended	I infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention I practices to prepare for ent practice was identified.	F				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	Ē	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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		185407	B. WING			04	04/02/2020	
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU			•	305 LANGD	DRESS, CITY, STATE, ZIP CODE ON STREET ET, KY 42503	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG) BE	(X5) COMPLETION DATE	
E 000	survey was conductor facility was found to CFR 483.73 Emerge	d Emergency Preparedness ed on 04/02/2020. The be in compliance with 42 ency Preparedness related to practice was identified.	E	000				

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.

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

TITLE

(X6) DATE

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Office of Inspector General

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		100708		B. WING		04/02/2020	
NAME OF D	ROVIDER OR SUPPLIER		STREET AND	RESS, CITY, STA	TE ZIR CODE		
				ON STREET	12, 211 0052		
LAKE CUI	MBERLAND REGIONAL I	HOSPITAL SCU		Γ, KY 42503			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) X (EACH CORRECTIVE ACTION SHOULD BE COMPLE		
N 000	Initial Comments			N 000			
	A COVID-19 focused conducted on 04/02/2	infection control survey 020. The facility was fo ursuant to 42 CFR 483.8 was identified.	und				

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

TITLE (X6) DATE