## 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		
185422			B. WING			08/31/2020	
NAME OF PROVIDER OR SUPPLIER  FLAGET MEMORIAL HOSPITAL NF				43	REET ADDRESS, CITY, STATE, ZIP CODE 105 NEW SHEPHERDSVILLE ROAD ARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A COVID-19 Focused Infection Control Survey		F	000			
	was conducted on found in compliand control regulations Centers for Medica and Centers for Dis	08/31/2020. The facility was e with 42 CFR 483.80 infection and has implemented the tre & Medicaid Services (CMS) sease Control and Prevention led practices to prepare for					
				,			
			-				
		IDER/SUPPLIER REPRESENTATIVE'S SIG			TITLE		(6) 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: 100747

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185422	B. WING	3		08/31/2020	
NAME OF PROVIDER OR SUPPLIER  FLAGET MEMORIAL HOSPITAL NF				STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004			
(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		E 00				
	A COVID-19 Focused Emergency Preparedness Survey was conducted on 08/31/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).				<		
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		O .			<u>.</u>		
							55
					20		
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		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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FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING\_ 100747 08/31/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD FLAGET MEMORIAL HOSPITAL NF BARDSTOWN, KY 40004 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was conducted on 08/31/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE