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

PRINTED: 11/19/2020 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	
185359		B. WING		11/18/2020		
NAME OF PROVIDER OR SUPPLIER ROBERTSON COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1030 KENTONTOWN ROAD, P O BOX 170 MOUNT OLIVET, KY 41064			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 000	A COVID-19 Focus	sed Infection Control Survey	F 00	00		
	11/18/2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Disease	17/2020 and concluded on acility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for ensus 50.				
				V		
ii.						
					a	
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	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 & MEDICARD SERVICES

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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	
	=	185359		B. WING		11	11/18/2020	
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, 2 1030 KENTONTOWN ROAD, P.C. MOUNT OLIVET, KY 41064	IP CODE	110/2020	
(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 ACC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Initial Comments		· .	E 00	0			
	Survey was initiated concluded on 11/18	sed Emergency Prep d on 11/17/2020 and 3/2020. The facility w with 42 CFR 483.73	as found		oute.			
					8			
	ű.							

							7	
AROBATORY	DIRECTORIS OF PROVIDE	ER/SUPPLIER REPRESENT	ATIVE CO.	LATURE .	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 o	f Inspector General				FORIV	APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
100656		100656	B. WING		11/18/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
ROBERT	ISON COUNTY HEAL		NTONTOWN FOLIVET, KY 4	ROAD, P O BOX 170 1064		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETE DATE
N 000 Initial Comments			N 000			
	was initiated 11/17/ 11/18/2020. The fa	ed Infection Control Survey 2020 and concluded on icility was found to be in nt to 42 CFR 483.80. Total				

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

TITLE

(X6) DATE