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

PRINTED: 01/20/2021 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 _			12/29/2020			
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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	OULD BE COMPLETION		
F 000	was initiated on 12/29 12/29/2020. The faci compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens	d Infection Control Survey 0/2020 and concluded on lity was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention	FC	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.

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		185359	B. WING		12	12/29/2020	
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 PREFI TAG		BE	(X5) COMPLETION DATE	
E 000	Survey was initiated of concluded on 12/29/2	d Emergency Preparedness on 12/29/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	DEFICIENCY)			

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

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: 100656

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	100656		B. WING	B. WING		29/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1020 KENTONTOWN BOAD, BO BOX 170							
ROBERTSON COUNTY HEALTH CARE FACILITY 1030 KENTONTOWN ROAD, P O BOX 170 MOUNT OLIVET, KY 41064							
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
N 000	Initial Comments		N 000				
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments A COVID-19 Focused Infection Control Survey was initiated on 12/29/2020 and concluded on 12/29/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 35						

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

TITLE (X6) DATE