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

PRINTED: 12/15/2020 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	
		185157	B. WING _		12	2/09/2020	
NAME OF PROVIDER OR SUPPLIER ROCKCASTLE REGIONAL HOSPITAL AND RESPIRATORY CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 145 NEWCOMB AVENUE MOUNT VERNON, KY 40456	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO		O BE COMPLETION	
F 000	INITIAL COMMENTS A COVID-19 focused conducted on 12/09/2 to be in compliance w 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.			ROPRIATE	DATE	
		SUPPLIER REPRESENTATIVE'S SIGNATUR		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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185157	B. WING _			12/	09/2020
	ROVIDER OR SUPPLIER	TAL AND RESPIRATORY CARE	,	STREET ADDRESS, CITY, STATE, ZIP 145 NEWCOMB AVENUE MOUNT VERNON, KY 40456	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI		(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 focused survey was conducte facility was found to be CFR 483.73 Emerger	d Emergency Preparedness d on 12/09/2020. The period in compliance with 42 ncy Preparedness related to practice was identified.					
ΙΔΒΟΡΔΤΟΡΥ	DIRECTOR'S OR PROVINCED	SUPPLIER REPRESENTATIVE'S SIGNATUF	r=	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 of Inspector General

	SUPPLIER/CLIA FION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
100374		B. WING		12/09/2020		
NAME OF PROVIDER OR SUPPLIER ROCKCASTLE REGIONAL HOSPITAL AND RESPIRAT STREET ADDRESS, CITY, STATE, ZIP CODE 145 NEWCOMB AVENUE MOUNT VERNON, KY 40456						
(X4) ID SUMMARY STATEMENT OF DEFI PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
N 000 Initial Comments A COVID-19 focused infection controducted on 12/09/2020. The facito be in compliance pursuant to 42 to No deficient practice was identified.	lity was found CFR 483.80.	N 000				

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

TITLE (X6) DATE