## 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	
		185157	B. WING		08/27	//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	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	A COVID-19 focusion conducted on 08/27 to be in compliance Control and has implemented to the control of the co	ed infection control survey was 7/2020. The facility was found with 42 CFR 483.80 Infection plemented the Centers for id Services (CMS) and a Control and Prevention ed practices to prepare for icient practice was identified.	FO				
AROPATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE	·	K6) 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.

Event ID: 180811

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID 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		
185157			B. WING_	B. WING			08/27/2020	
NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE REGIONAL HOSPITAL AND RESPIRATORY CARE				STREET ADDRESS, CITY, STATE, ZIF 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 PREFIX TAG	PROVIDER'S PLAN (  (EACH CORRECTIVE A  CROSS-REFERENCED T  DEFICIE	CTION SHOULD BE O THE APPROPRIAT		(X5) COMPLETION DATE	
E 000	A COVID-19 focuses survey was conducted facility was found to CFR 483.73 Emerge	d Emergency Preparedness ed on 08/27/2020. The be in compliance with 42 ency Preparedness related to practice was identified.	EC	000				
						,		
4.2								
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	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.

PRINTED: 09/03/2020 FORM APPROVED Office of Inspector General (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING\_ 100374 08/27/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 145 NEWCOMB AVENUE **ROCKCASTLE REGIONAL HOSPITAL AND RESPIRAT** MOUNT VERNON, KY 40456 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 08/27/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE