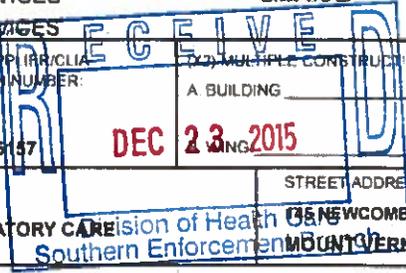


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SCD

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FORM APPROVED
OMB NO. 0938-0391



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185157 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ | (X3) DATE SURVEY COMPLETED 10/29/2015 |
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| NAME OF PROVIDER OR SUPPLIER ROCKCASTLE REGIONAL HOSPITAL AND RESPIRATORY CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 98 NEWCOMB AVENUE MOUNT VERNON, KY 40456 |
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| (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 |
|--------------------|---|---------------|--|----------------------|
| F 000 | INITIAL COMMENTS | F 000 | | |
| F 281 SS=D | <p>483 20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility policy, and review of the Textbook for Long-Term Care Nursing Assistants, it was determined the facility failed to provide services that meet professional standards of quality for two (2) of twenty (20) sampled residents (Resident #2 and Resident #17) related to catheter care. A review of Mosby's Textbook for Long-Term Care Nursing Assistants revealed urinary catheters should be secured to the resident's inner thigh, or to a man's abdomen. However, the facility developed a care plan for Resident #2 and Resident #17 that stated the catheter "may" be secured "if pulling is problematic," and failed to ensure the residents' catheters were secured.</p> <p>The findings include: Review of the facility policy, "Resident Interdisciplinary Care Plan," with a revision date of August 2014 revealed an interdisciplinary care planning conference was held to identify residents' needs and to establish obtainable goals, and an appropriate plan of action was designed to ensure optimal levels of activity and independence for all residents.</p> | F 281 | <p>Foley Catheters for resident's #2 and #17 were secured with tube holder to inner thigh. Residents #2 and #17 care plans were updated to include "the catheter is secured to inner thigh to prevent excess catheter movement and friction at insertion site". All residents were reviewed to identify residents with order for Foley Catheters. Residents with Foley Catheters in place will be assessed for securement of catheter to inner thigh (or for male to abdomen). Care plans for residents with Foley Catheters will be updated to include the intervention "secure catheter to inner thigh (or for male to abdomen) to prevent excess catheter movement or friction at insertion site". Urinary Catheter Care Policy was revised to include "secure catheter to inner thigh (or for male to abdomen)".</p> <p>Foley Catheter Insertion Policy was revised to include "secure catheter to inner thigh (or for male to abdomen)".</p> <p>Foley Catheter Management Care Plans were revised. "May" and "if pulling is problematic" statements were removed from Foley Catheter Management Care Plans. Foley Catheter Management Care Plan interventions was added "secure catheter to inner thigh (or for male to abdomen) to prevent excess movement or friction at insertion site". Education was provided to RNs, LPNs and SRNAs on policy revisions (Urinary Catheter Care and Foley Catheter Insertion) of "secure catheter to inner thigh (or for male to abdomen)" on December 8, 2015 by Chief Nursing Officer.</p> <p>Education was provided to RNs, LPNs and SRNAs on Foley Catheter Management Care Plan revisions "secure catheter to inner thigh (or for male to abdomen)" on December 8, 2015 by Chief Nursing Officer. Staff was informed of expectation that Foley Catheters will be secured to prevent excess movement or friction at insertion site on December 8, 2015 by Chief Nursing Officer.</p> | |

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| 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.

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| NAME OF PROVIDER OR SUPPLIER ROCKCASTLE REGIONAL HOSPITAL AND RESPIRATORY CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 145 NEWCOMB AVENUE MOUNT VERNON, KY 40456 | | |
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| F 281 | <p>Continued From page 1</p> <p>Review of Mosby's Textbook for Long-Term Care Nursing Assistants, Seventh Edition, revealed catheters should be secured to the inner thigh, or secured to a man's abdomen. The textbook stated this prevents excess catheter movement and friction at the insertion site. The catheter should be secured with a tube holder, tape, or other devices as the nurse directed.</p> <p>1. Review of the medical record for Resident #2 revealed the facility admitted the resident on 01/30/15 with a readmission date of 09/22/15, with diagnoses that include Chronic Respiratory Failure, Pyelonephritis, Ventilator Dependency, Tracheostomy, Gastrostomy, Colostomy, Severe Sepsis, Pressure Stage IV, Paraplegia, and Renal Calculi.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 09/10/15 revealed Resident #2 required the use of an indwelling urinary catheter. According to the resident's MDS, the resident was not interviewable.</p> <p>Review of the comprehensive care plan dated 09/22/15 for Resident #2 revealed the facility identified that the resident had an indwelling catheter, however, the care plan stated, "May anchor Foley [urinary catheter] to leg with tape or tubing holder if pulling is problematic."</p> <p>Observation of Resident #2 on 10/28/15, at 1:21 PM, revealed the resident was lying on his/her back in bed with the urinary catheter tubing draped over the resident's left leg. The urinary catheter tubing was not secured to the resident to prevent pulling of the urinary catheter tubing.</p> <p>2. Review of Resident #17's medical record revealed the facility admitted the resident on 04/01/14 with diagnoses of Anoxic Brain Injury, Diabetes Mellitus, Seizure Disorder, Coronary Artery Disease, Mental Retardation, Parkinson's</p> | F 281 | <p>Random weekly audits will be conducted to identify compliance with Foley Catheter secured to inner thigh (or for male to abdomen) until 100% compliance reached and maintained. The random audits will be conducted weekly by unit coordinators on 100% of residents with foley catheters. Monthly reviews of compliance will be ongoing and incorporated into organizational performance improvement plan.</p> <p>Results of audits will be shared with Nursing Units, Nursing Management, and LTC Performance Improvement and incorporated in organization performance Improvement program. Care Plans will be reviewed as part of care plan meeting to ensure compliance with intervention of "Foley Catheter secured". Results of review will be incorporated into organizational performance improvement program.</p> | 12/10/2015 | |

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| F 281 | Continued From page 2 disease, and Tardive Dyskinesia. Review of the Quarterly Minimum Data Set (MDS) dated 09/24/15 revealed Resident #17 required an indwelling urinary catheter. According to the resident's MDS, the resident was not interviewable. Review of Resident #17's Care Plan dated 05/13/15, revealed the facility identified the resident required the use of a urinary catheter with interventions to "position catheter bag and tubing below the level of the bladder" and "may anchor Foley to leg with tape or tubing holder if pulling is problematic." Observation on 10/27/15 at 9:35 AM with RN #1 revealed Resident #17 was in bed. The resident's urinary catheter tubing was lying over the left leg and attached to a drainage bag; however, Resident #17's catheter tubing was not secured to the resident's leg. Interview with the Director of Nursing (DON) on 10/29/15 at 4:05 PM revealed she was aware residents' care plans and the facility's policy stated that the resident's catheter tubing "may" be anchored to the resident. She stated they were worded that way because some residents requested that the catheter not be anchored (there was no evidence Resident #2 or Resident #17 had requested that their urinary catheters not be secured). Furthermore, she stated that the facility used Mosby's Textbook for Long-Term Care Nursing Assistants, Seventh Edition, for reference with urinary catheter care, and nurses and Certified Nursing Assistants (CNAs) were responsible for ensuring that residents' urinary catheters were secured. | F 281 | | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | | | |

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| F 315 | <p>Continued From page 3</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of a facility policy, and the Mosby Textbook for Long-Term Care Nursing Assistants, it was determined the facility failed to ensure urinary catheter tubing was secured to prevent possible injury/trauma of the urinary tract for two (2) of twenty (20) sampled residents (Resident #2 and Resident #17). The Mosby Textbook for Long-Term Care Nursing Assistants utilized by the facility stated urinary catheters should be secured to prevent excess movement and friction; however, the facility policy and care plans for Residents #2 and #17 stated the catheters "may" be secured and failed to ensure that urinary catheters were secured for the residents.</p> <p>The findings include:</p> <p>Review of a facility policy titled "Urinary Catheter Care," dated June 1994, revealed the catheter may be secured to inner thigh (females) or lateral leg or abdomen (males) to prevent strain/friction at insertion site, prevent excessive movement of</p> | F 315 | <p>Foley Catheters for resident #2 and #17 were secured with tube holder to inner thigh. Residents #2 and #17 care plans were updated to include "the catheter is secured to inner thigh to prevent excess catheter movement and friction at insertion site". All residents were reviewed to identify residents with order for Foley Catheters. Residents with Foley Catheters in place will be assessed for securement of catheter to inner thigh (or for male to abdomen). Care plans for residents with Foley Catheters will be updated to include the intervention "secure catheter to inner thigh (or for male to abdomen) to prevent excess catheter movement or friction at insertion site". Urinary Catheter Care Policy was revised to include "secure catheter to inner thigh (or for male to abdomen)". Foley Catheter Insertion Policy was revised to include "secure catheter to inner thigh (or for male to abdomen)".</p> <p>Foley Catheter Management Care Plans were revised. "May" and "if pulling is problematic" statements were removed from Foley Catheter Management Care Plans. Foley Catheter Management Care Plan interventions was added "secure catheter to inner thigh (or for male to abdomen) to prevent excess movement or friction at insertion site".</p> <p>Education was provided to RNs, LPNs and SRNAs on policy revisions (Urinary Catheter Care and Foley Catheter Insertion) of "secure catheter to inner thigh (or for male to abdomen)" on December 8, 2015 by Chief Nursing Officer.</p> <p>Education was provided to RNs, LPNs and SRNAs on Foley Catheter Management Care Plan revisions "secure catheter to inner thigh (or for male to abdomen)" on December 8, 2015 by Chief Nursing Officer.</p> <p>Staff was informed of expectation that Foley Catheters will be secured to prevent excess movement or friction at insertion site on December 8, 2015 by Chief Nursing Officer.</p> <p>Random weekly audits will be conducted to identify compliance with Foley Catheter secured to inner thigh (or for male to abdomen) until 100% compliance reached and maintained. The random audits will be conducted weekly by unit coordinators on 100% of residents with foley catheters. Monthly reviews of compliance will be ongoing and incorporated into organizational performance improvement plan.</p> | | |

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| F 315 | <p>Continued From page 4</p> <p>the catheter, and ensure the free flow of urine. The policy stated the catheter may be taped with non-allergenic tape or secured with an anchoring device. Further review of the policy revealed staff should keep enough slack in the catheter tubing to allow the patient to move about without the catheter pulling on the urethra.</p> <p>Review of Mosby's Textbook for Long-Term Care Nursing Assistants, Seventh Edition, revealed catheters should be secured to the inner thigh, or secured to a man's abdomen. The textbook stated this prevents excess catheter movement and friction at the insertion site. The catheter should be secured with a tube holder, tape, or other devices as the nurse directed.</p> <p>1. Review of the medical record for Resident #2 revealed the facility admitted the resident on 01/30/15 and was readmitted on 09/22/15, with diagnoses that include Chronic Respiratory Failure, Pyelonephritis, Ventilator Dependency, Tracheostomy, Gastrostomy, Colostomy, Severe Sepsis, Pressure Stage IV, Paraplegia, and Renal Calculi.</p> <p>Review of Resident #2's comprehensive care plan dated 09/22/15 revealed the facility addressed the use of the urinary catheter with interventions that included positioning the catheter bag and tubing below the level of the bladder and "may anchor Foley to leg with tape or tubing holder if pulling is problematic."</p> <p>Catheter care was observed to be performed by facility staff for Resident #1 on 10/28/15 at 1:21 PM. The catheter was attached to a bedside drainage bag; however, the tubing was not secured to the resident's leg.</p> | F 315 | <p>Results of audits will be shared with Nursing Units, Nursing Management, and LTC Performance Improvement and incorporated in organization performance improvement program. Care Plans will be reviewed as part of care plan meeting to ensure compliance with intervention of "Foley Catheter secured". Results of review will be incorporated into organizational performance improvement program.</p> | 12/10/2015 | |

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| F 315 | <p>Continued From page 5</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 10/29/15 at 3:47 PM revealed she was trained to anchor an indwelling urinary catheter to the resident when performing catheter care. She stated she tried to keep Resident #2's catheter anchored, but the resident pulled off the anchor. Furthermore, she stated that if she were performing catheter care on a resident and noticed that their catheter was not anchored, she would get a device from the supply room and ensure the catheter was anchored.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/29/15 at 5:32 PM revealed that all nurses and nursing assistants were responsible for ensuring residents' indwelling urinary catheters were anchored to the resident's leg or abdomen. She stated that sometimes the anchor came off and they replaced them.</p> <p>Interview with the East Unit Coordinator on 10/28/15 at 6:37 PM revealed the facility's policy stated that they may or may not anchor urinary catheters. She stated they tried to keep anchors on all residents that required indwelling urinary catheters. Furthermore, she stated the nurse was responsible for ensuring catheter tubing was anchored to their leg when nurses completed rounds and assessments. She also stated that Resident #2 routinely removed his/her anchor, which was why the resident did not always have one.</p> <p>Interview with the Director of Nursing (DON) on 10/29/15 at 4:05 PM revealed the facility utilized the Mosby's Textbook for Long-Term Care Nursing Assistants, Seventh Edition, as a reference for urinary catheter care. She stated nurses and Certified Nursing Assistants (CNAs)</p> | F 315 | | | |

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| F 315 | <p>Continued From page 6</p> <p>were responsible for ensuring residents' urinary catheters were anchored. She also stated she was aware that the facility's policy and residents' care plans stated that the catheter tubing "may" be anchored to the resident. She stated it was worded in that manner because the facility had many residents that requested the catheter not be anchored (there was no evidence Resident #2 or Resident #17 had requested their urinary catheters not be anchored).</p> <p>2. Review of Resident #17's medical record revealed the facility admitted the resident on 04/01/14 with diagnoses of Anoxic Brain Injury, Diabetes Mellitus, Seizure Disorder, Coronary Artery Disease, Mental Retardation, Parkinson's disease, and Tardive Dyskinesia.</p> <p>Review of Resident #17's Quarterly Minimum Data Set (MDS) dated 09/24/15 revealed the resident required an indwelling urinary catheter. According to the resident's MDS, the resident was not interviewable.</p> <p>Review of Resident #17's Comprehensive Care Plan dated 05/13/15 revealed the facility identified the resident had an indwelling urinary catheter and developed an intervention that stated, "May anchor Foley to leg with tape or tubing holder if pulling is problematic."</p> <p>Observation of Resident #17 with Registered Nurse (RN) #1 on 10/27/15 at 9:35 AM, revealed the resident's indwelling urinary catheter tubing was attached to the drainage bag; however, the tubing was not secured to Resident #17's leg. RN #1 explained during an interview on 10/29/15 at 6:45 PM, that she did not think there was any documentation reflecting the last time anyone documented the urinary catheter was secured.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 revealed Resident #17's indwelling</p> | F 315 | | | |

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| F 315 | Continued From page 7 urinary catheter was usually secured to the resident's leg and did not remember if the "anchor" (device to secure the catheter tubing) came off the resident's leg during a bath. SRNA#2 stated she should have secured the catheter tubing to Resident #17's leg after the resident's bath. Interview with the Director of Nursing (DON) on 10/29/15 at 4:05 PM revealed she was aware residents' care plans and the facility's policy stated that the resident's catheter tubing "may" be anchored to the resident. She stated they were worded that way because some residents requested that the catheter not to be anchored (there was no evidence Resident #2 or Resident #17 had requested that their urinary catheters not be secured). Furthermore, she stated that the facility used Mosby's Textbook for Long-Term Care Nursing Assistants, Seventh Edition, for reference with urinary catheter care, and nurses and Certified Nursing Assistants (CNAs) were responsible for ensuring that residents' urinary catheters were secured. | F 315 | | |
| F 322 SS=D | 483 25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration | F 322 | Education was provided to Nurse #4 to check gastrostomy tube for proper placement prior to medication administration on October 30, 2015 by Chief Nursing Officer. Education was provided on "injecting small amount of air while listening" and "aspirating stomach contents" to verify proper placement of gastrostomy tube. The nurse was also provided education on the Medication Administration Policy on October 30, 2015 by Chief Nursing Officer. To address other residents with potential to be affected, education was provided to RNs and LPNs to verify patency and placement of enteral tubes prior to administering medication on December 8, 2015 by Chief Nursing Officer | |

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| F 322 | <p>Continued From page 8</p> <p>pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate treatment and services were provided for one (1) unsampled resident (Resident A). Facility staff administered medications to Resident A through the resident's gastrostomy tube (feeding tube); however, staff failed to check the feeding tube to ensure it was properly placed prior to administering medications.</p> <p>The findings include:</p> <p>A review of the Medication Administration Policy (dated 07/01/01) revealed staff should inject a small amount of air with a syringe into the gastrostomy tube while listening to the resident's stomach with a stethoscope for gurgling sounds. Staff should then aspirate the stomach contents with a syringe prior to administering medications into the gastrostomy tube.</p> <p>Observation conducted during medication administration on 10/29/15, at 9:15 AM, revealed Licensed Practical Nurse (LPN) #4 flushed Resident A's feeding tube with 30 milliliters of water without checking the resident's gastrostomy</p> | F 322 | <p>Medication Administration Policy was reviewed. RNs and LPNs will complete a policy review and competency assessment for Administration of medication via enteral tubes. Competency Observation Audits will be implemented to provide direct observation of medication administration via enteral tubes. Audits will include the element "assessing of enteral tube proper placement prior to medication administration" The Competency Audits will be conducted by unit coordinators. The Audits will be conducted monthly and include observation of at least 30 nurses</p> <p>Competency Audits will be incorporated into ongoing organizational performance improvement activities</p> | 12/ 10/2015 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185157 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/29/2015 |
|--|--|---|---|----------------------|---|
| 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 PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 322 | <p>Continued From page 9</p> <p>tube for placement. LPN #4 then administered Seroquel (antipsychotic) 25 milligrams (mg); Pepcid (anti-ulcer) 20 mg; Aspirin (analgesic) 81 mg; Escitalopram (antidepressant) 20 mg; Oxycodone Hydrochloride (opioid pain medication) 10 mg; and Ativan (antianxiety) 0.5 mg to Resident A through the resident's feeding tube. Observation revealed the LPN failed to check to ensure the resident's feeding tube was placed in the resident's stomach prior to flushing the resident's feeding tube with water and administering medications.</p> <p>Interview with LPN #4 on 10/29/15, at 4:05 PM revealed the LPN was aware she was responsible to check the feeding tube for placement immediately prior to administering medications. The LPN stated she had checked Resident A's gastrostomy tube for placement approximately one hour before and should have checked again prior to administering the resident's medications.</p> <p>Interview conducted with the Director of Nursing (DON) on 10/29/15, at 4:10 PM, revealed she expected staff to check feeding tube placement once every shift, and would only check again if something was found to be abnormal, such as a clogged tube. However, a review of the facility's policy revealed staff should check a resident's feeding tube placement prior to administering medications. The DON revealed nurses' competency for administering medication via a feeding tube was checked annually, and no problems had been identified.</p> | F 322 | | | |

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: 185157 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2015 |
| 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 PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two story, Type II (111)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET SYSTEM with ANTIFREEZE LOOP)</p> <p>EMERGENCY POWER: Type I diesel generator</p> <p>A life safety code survey was initiated and concluded on 10/27/15, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p> | K 000 | | | |
| 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.