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

PRINTED: 08/14/2020 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		
		18G019	B, WING_			08/0	04/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 2				24	TREET ADDRESS, CITY, STATE, ZIP CODE 141 SOUTH HIGHWAY 27 OMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCY)			(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A COVID-19 focused infection control survey was conducted on 08/04/2020. The facility was found to be in compliance with 42 CFR 483.470 Physical Environment and has implemented the		W	000		×	- ⊗
	and Centers for Dise (CDC) recommended	Medicaid Services (CMS) ase Control and Prevention practices to prepare for ent practice was identified.					
-							
ARORATORY	DIRECTOR'S OR PROMISE	/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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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		18G019	B. WING			3/04/2020	
	ROVIDER OR SUPPLIER D ICF/IID, UNIT 2			STREET ADDRESS, CITY, STATE, ZIP COO 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETION DATE	
E 000	A COVID-19 focused survey was conducted facility was found to I CFR 483.475 Emerg	d Emergency Preparedness of on 08/04/2020. The period in compliance with 42 ency Preparedness related ent practice was identified.	E 00	00			
LABORATORY	CIRECTOR'S OR PROVIDE	VSUPPLIER REPRESENTATIVE'S SIGNATI	URE	TITLE		(X6) DATE	

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:_ B. WING 101089 08/04/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 **OAKWOOD ICF/IID, UNIT 2** SOMERSET, KY 42501 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 1 000 Initial Comments 1000 A COVID-19 focused infection control survey was conducted on 08/04/2020. No deficient practice was identified.

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

TITLE

(X6) DATE