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

PRINTED: 03/10/2021 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		
			7. BOLDING		c		
		18G018	B. WING		02/10/2021		
NAME OF PROVIDER OR SUPPLIER  OAKWOOD ICF/IID, UNIT 4				STREET ADDRESS, CITY, STATE, ZIP CODE  2441 SOUTH HIGHWAY 27  SOMERSET, KY 42501			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	JLD BE COMPLETION	
W 000	A complaint investic COVID-19 focused initiated on 02/09/2 02/10/2021. The cand no deficient prafacility was found to CFR 483.470 Physimplemented the CMedicaid Services Disease Control arrecommended practicol COVID-19.	igation (KY31686) and a Infection control survey was 021 and concluded on omplaint was unsubstantiated actice was identified. The to be in compliance with 42 cical Environment and has tenters for Medicare & (CMS) and Centers for and Prevention (CDC) ctices to prepare for	W	0000	DEFICIENCY)		(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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.

PRINTED: 03/10/2021 FORM APPROVED 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: \_\_\_\_ C 101091 B. WING 02/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 **OAKWOOD ICF/IID, UNIT 4** SOMERSET, KY 42501 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 1000 **Initial Comments** 1000 A complaint investigation (KY31686) and a COVID-19 focused infection control survey was initiated on 02/09/2021 and concluded on 02/10/2021. The complaint was unsubstantiated. No deficient practice was identified.

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

TITLE

(X6) DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  C  18G018  B. WING  DENTIFICATION NUMBER:  A. BUILDING  C  02/10/	0/2021			
02/10/	DI ZUZ I			
OAKWOOD ICF/IID, UNIT 4  2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501	STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ULD BE COMPLETION			
A COVID-19 focused Emergency Preparedness survey was initiated on 02/09/2021 and concluded on 02/10/2021. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	(X6) DATE			

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