

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: 18G018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS 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 and no deficient practice was identified. The facility was found to be in compliance with 42 CFR 483.470 Physical Environment and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	W 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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2021
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NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 4	STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501
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I 000	<p>Initial Comments</p> <p>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.</p>	I 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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E 000	<p>Initial Comments</p> <p>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.</p>	E 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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