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

PRINTED: 11/03/2020 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		
		185246	B. WING			10/14/2020	
NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH AND REHABILITATION CENTER				37	TREET ADDRESS, CITY, STATE, ZIP CODE 71 WEST MAIN STREET RODHEAD, KY 40409		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A COVID-19 focused infection control survey was conducted on 10/14/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and		F	000			
	(CDC) recommended	Control and Prevention I practices to prepare for ent practice was identified.					
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					Se		
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.

## DEPARTMENT OF HEALTH AND HUMAN 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	
185246			B. WING		10.	10/14/2020	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 71 WEST MAIN STREET BRODHEAD, KY 40409			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION: TAG CROSS-REFERENCED TO THE A DEFICIENCY)		SHOULD BE COMPLETION		
E 000		ed Emergency Preparedness ted on 10/14/2020. The	E 000				
8	facility was found to CFR 483.73 Emerg	be in compliance with 42 ency Preparedness related to t practice was identified.					
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LABORATORY	/ DIDECTOR'S OR BROWNS	R/SLIPPLIER REPRESENTATIVE'S SIGNATU	IDE S	TITLE		(X6) DATE	

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PRINTED: 11/03/2020 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: \_ B. WING 100375 10/14/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **371 WEST MAIN STREET ROCKCASTLE HEALTH AND REHABILITATION CENTI BRODHEAD, KY 40409** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 N 000 **Initial Comments** A COVID-19 focused infection control survey was conducted on 10/14/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

No deficient practice was identified.

TITLE

(X6) DATE