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

PRINTED: 09/29/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR WEDICARE &	MEDICAID SERVICES			<u> </u>	0.0000-0001		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION		(X3) DATE SURVEY COMPLETED		
185246			B. WING			C 09/16/2020		
	ROVIDER OR SUPPLIER	HABILITATION CENTER	STRE 371 V	STREET ADDRESS, CITY, STATE, ZIP CODE  371 WEST MAIN STREET  BRODHEAD, KY 40409				
(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 CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 000	An abbreviated star a COVID-19 focused	S  Indard survey (KY32355) and Infection control survey was 1/2020. The complaint was	F 000		él.			
	unsubstantiated and identified. The facili compliance with 42 and has implemented	I no deficient practice was ty was found to be in CFR 483.80 Infection Control ed the Centers for Medicare & CMS) and Centers for d Prevention (CDC) tices to prepare for						
LABORATOR	Y DIRECTOR'S OR PROVIDE	ER/SLIPPLIER REPRESENTATIVE'S SIGNATU	IRE	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 CENTERS FOR MEDICARE & MEDICARD SERVICES

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON	(X2) MULTIPLE CONSTRUCTION			
		IDENTIFICATION NUMBER:	A, BUILDING		(X3) DATE SURVEY COMPLETED		
				C	С		
	185246				. 09/	6/2020	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  371 WEST MAIN STREET  BRODHEAD, KY 40409				
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E 000	survey was condu facility was found to CFR 483,73 Emer	sed Emergency Preparedness cted on 09/16/2020. The to be in compliance with 42 gency Preparedness related to ent practice was identified.	E 000				
LABORATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE	

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Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ B. WNG 09/16/2020 100375 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **371 WEST MAIN STREET ROCKCASTLE HEALTH AND REHABILITATION CENT! BRODHEAD, KY 40409** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY32355) and a COVID-19 focused infection control survey was conducted on 09/16/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE