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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185246 | A. BUILDING _____ B. WING _____ | C 09/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROCKCASTLE HEALTH AND REHABILITATION CENTER | 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 PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>An abbreviated standard survey (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 with 42 CFR 483.80 Infection Control 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. The total census was 82. | F 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| | 185246 | A. BUILDING _____ B. WING _____ | C 09/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROCKCASTLE HEALTH AND REHABILITATION CENTER | 371 WEST MAIN STREET BRODHEAD, KY 40409 |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A COVID-19 focused Emergency Preparedness survey was conducted on 09/16/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified. | E 000 | | |

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Office of Inspector General

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 100375 | A. BUILDING _____ B. WING _____ | C 09/16/2020 |

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|---|---|---|---|---|
| N 000 | Initial Comments<br><br>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. | N 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE